North Carolina Department of Health and Human Services

BLUEPRINT FOR CHANGE

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

North Carolina's plan for mental health, developmental disabilities and substance abuse services

State Plan 2006

An Analysis of State Plans 2001 - 2005

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645
Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

October 31, 2006

The Honorable Martin Nesbitt, Jr., Co-Chair
Joint Legislative Oversight Committee on Mental Health,
Developmental Disabilities and Substance Abuse Services
North Carolina Senate
Room 300-B, Legislative Office Building
Raleigh, NC 27601-2808

The Honorable Verla C. Insko, Co-Chair
Joint Legislative Oversight Committee on Mental Health,
Developmental Disabilities and Substance Abuse Services
North Carolina House of Representatives
Room 2121, Legislative Building
Raleigh, NC 27601-1096

Dear Senator Nesbitt and Representative Insko:

Please accept State Plan 2006: An Analysis of State Plans 2001 – 2005. This Plan responds to the legislative requirement to produce a single document that contains a cumulative statement of all still applicable provisions of prior plans. This Plan also reflects the continued transformation of the mental health, developmental disabilities and substance abuse services system in North Carolina. It will serve as the State Plan for State fiscal year 2007. State Plan 2006 is organized as follows:

- Chapter 1: Introduction – This chapter addresses the 2006 legislative requirements and places reform as a national effort.
- Chapter 2: Original Provisions of Reform – This chapter organizes the original provisions of the 2001 reform legislation and the provisions of the prior five State plans in the context of a community based service system.
- Chapter 3: The Community of People to be Served – This chapter describes who the system is designed to serve and the changes that have occurred over five years in criteria for target population definitions.
- Chapter 4: Governance of the System – This chapter describes the roles and responsibilities of governing bodies at the local and state levels.

- Chapter 5: Funding of the System – This chapter describes the current funding of the system, the finance strategy and efforts for standardization throughout the system.

- Chapter 6: Performance Goals and Accountability for Effectiveness and Costs – This chapter addresses quality management of the system, including effective outcomes for consumers and their families, system performance, and service monitoring.

- Chapter 7: The Local Management of the System – This chapter describes local business plans, the DHHS-LME performance contract, core functions of an LME, accreditation and building community capacity.

- Chapter 8: The Delivery of Services – This chapter addresses person-centered planning, the array and continuum of services, state operated facilities, efforts to focus on best practices and workforce development.

- Appendices include excerpts from the original reform legislation, a glossary, an index to State Plans 2001-2005 by topic and the entire set of detailed tasks from State Plans 2001 – 2005. The status for each task is given as well as an explanation if applicable.

I continue to be grateful for your leadership and that of the Legislative Oversight Committee members in helping guide this transformation of our public mh/dd/sas system. The leadership team at the Division of MH/DD/SAS continues to be highly dedicated and committed to the Plan's advancement. I look forward to another active and rewarding year.

Sincerely yours,

Carmen Hooker Odom

CHO/seh

Cc: Legislative Oversight Committee
Dr. Allen Dobson, Assistant Secretary for Health Policy and Medical Assistance
Dan Stewart, Deputy Secretary for the Department of Health and Human Services
Jackie Sheppard, Assistant Secretary for Long-Term Care and Family Services
Sharnese Ransome, Office of Government Relations
Michael Moseley, DMH/DD/SAS Director
Leza Wainwright, DMH/DD/SAS Deputy Director

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Chapter I. Introduction

The transformation of the public system of mental health, developmental disabilities and substance abuse services began in the fall of 2001 after the North Carolina General Assembly enacted legislation for the reform of the system.[1] That legislation instructed the State to publish an annual State Plan to address how reform would be implemented. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) published the first State Plan in November 2001 and since that time has published an annual plan on July 1 of each State fiscal year.[2]

This document provides an analysis of the five previous State Plans and serves as the State Plan for State fiscal year 2006-2007 and thereby meets the requirements of legislation passed in July 2006.

Legislative Requirements for State Plan 2006

Session Law 2006-142, House Bill 2077, Section 2.(b) states[3]:

> "The North Carolina Department of Health and Human Services (DHHS) shall review all State Plans for Mental Health, Developmental Disabilities and Substance Abuse Services, implemented after July 1, 2001, and before the effective date of this act and produce a single document that contains a cumulative statement of all still applicable provisions of those Plans. This cumulative document shall constitute the State Plan until July 1, 2007."

House Bill 2077 also specifies that beginning July 1, 2007, the State Plan will be issued every three years as a strategic plan that identifies specific goals and benchmarks for determining progress. To support that aim, Session Law 2006-66, Senate Bill 1741, Section 10.28 entitled "Changes to the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services" is written as follows.

> "Section 10.28. Independent consultants hired by the Department from funds appropriated in this act for this purpose shall undertake the following tasks:
>
> (1) Assist DHHS with the strategic planning necessary to develop the revised State Plan as required under G.S. 122C-102. The State Plan shall be coordinated with local and regional crisis service plans by area authorities and county programs."

[1] See North Carolina Session Law 2001-437, House Bill 381, Section 1.5.
[2] The previous State Plans can be found on the Division's web site: http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/index.htm
[3] See the Division's Communication Bulletin #059 entitled "Session Law 2006-142 House Bill 2077" and Communication Bulletin #057 entitled: "Modified Timing of State Plan 2006."

Therefore, this document provides an analysis of past efforts to transform the public mental health, developmental disabilities and substance abuse services system, clarifies the work to be accomplished in State fiscal year 2006-2007 and lays the groundwork for the upcoming three-year strategic plan to be developed for 2007-2010.

Reform as a National Effort

As the federal government and other states engage in the development of a more coherent, coordinated and effective plan and strategy for reform of mental health, developmental disabilities and substance abuse services, so has North Carolina committed to a transformation designed to be responsive to all stakeholders. Table 1 illustrates how the Division's vision, mission and guiding principles complement national and federal goals and actions for reform of the public mental health, developmental disabilities and substance abuse services and supports.

Table 1. Principles and goals of national mental health, developmental disabilities & substance abuse system reform

PRINCIPLES GUIDING NATIONAL AND STATE MH/DD/SAS REFORM	President's New Freedom Commission on Mental Health *"Achieving the Promise: Transforming Mental Health Care in America"* (July 2003) & SAMHSA's: ***Federal Action Agenda*** - (2005)	The President's Committee for People with Intellectual Disabilities *"A Charge We Have To Keep: A Road Map to Personal and Economic Freedom for Persons with Intellectual Disabilities in the 21st Century" - (2004)*	Federal Center for Medicare & Medicaid Services (CMS) *"Quality Framework"* - (2002)
Participant Driven ❖ Assure that the system is person-centered – "Participant" refers to persons who are seeking assistance in overcoming or adjusting to life situations that involve MH/DD/SA issues and is inclusive of the terms "consumers," "family members, " "clients" and "patients".	• Mental health care is **consumer and family driven.** • Focus on the desired **outcomes of mental health care** including employment, self-care, interpersonal relationships and community participation.	• A new road map is required, one that aligns a public rhetoric to desired outcomes. It needs to be **based** on the **principles** of **self-determination**.	• **Participant centered** service **planning** and **delivery:** Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. • **Participant outcomes** and satisfaction. • **Participants** have the **authority** and are supported to **manage** their own **supports**.
Community-Based ❖ Focus on community level models of care that effectively and efficiently coordinate treatment and the delivery of services.	• **Community-level models** of care that coordinate multiple health and human service providers and private and public payers. • Focus on **community-level models** of care that efficiently coordinate the multiple heath and human service providers and public and private payers involved in mental health, developmental disabilities and substance abuse treatment and delivery of services.	• People to have the freedom to **live** a meaningful life in the **community.** • Examine provider attitudes, behaviors relative to inclusion of persons with intellectual disabilities in **community-based** and private practice settings.	• **Provider capacity** and **capabilities:** There are sufficient quality agency and individual providers to meet the needs of participants in their communities. • Participant **access.** • Individuals and families can readily obtain **information** concerning the **availability** of Home and Community Based **Services**, how to apply and, if desired, offered a referral.
Prevention Focused ❖ The utilization of information technology and early screening, assessment, referral to services is common practice and is valued as essential to overall health.	• **Early** mental health **screening**, **assessment** and **referra**l to services are common practice. • Advance and **implement** a national **campaign** to reduce the stigma of seeking care, **providing facts** and a national strategy for suicide prevention	• American citizens with intellectual disabilities will have **access** to a **complete range** of **health care services** and **supports** from medical, dental and other health professional providers	• Participants have **continuous access** to assistance as needed to obtain and coordinate services and promptly address issues. • Regular, systematic and objective methods-including **obtaining** the participant's **feedback**-are used to **monitor** the individual's well being, health status and the **effectiveness** of **services** in enabling the individual to achieve his or her personal goals.

PRINCIPLES GUIDING NATIONAL AND STATE MH/DD/SAS REFORM	**President's New Freedom Commission on Mental Health,** *"Achieving the Promise: Transforming Mental Health Care in America"* – (July 2003) & **SAMHSA's: *Federal Action Agenda*** - (2005)	***The President's Committee for People with Intellectual Disabilities*.** *"A Charge We Have To Keep: A Road Map to Personal and Economic Freedom for Persons with Intellectual Disabilities in the 21st Century" - (2004)*	**Federal Center for Medicare & Medicaid Services (CMS)** *"Quality Framework"* - (2002)
Recovery Oriented ❖ System elements will be seamless: consumers, families, policymakers, advocates and qualified providers will unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.	• **Involve consumers** and **families** fully in orienting the mental health system toward **recovery**. • **Excellent** mental health **care** is delivered and research is accelerated. • Utilize **data** and quality **information** to **engage** in actions that lead to continuous **improvement** in the Home and Community Based Services.	• **Develop meaningful assessments** and **accountability** by establishing an Intra-Agency Task Force, which would be facilitated by the U.S. Department of Education and include national experts, to provide ongoing guidance to states on **universally relevant standards** and appropriate assessments for students with intellectual disabilities under the No Child Left Behind Act.	• The service system **promotes** the effective and efficient provision of services and supports by **engaging** in systematic **data collection** and **analysis** of **program performance** and **impact**.
Best-Practice Based ❖ Use mental health research findings deemed to be "Evidenced-Based Best Practice" to influence the delivery of services.	• Advance **evidence-based practices** using dissemination and demonstration projects and create a public-private partnerships to guide their implementation. • Use Mental Health **Research** Findings to ▶ **Influence** the Delivery of **Services** • **Align** relevant Federal **programs** to **improve access** and **accountability** for mental health services. • **Create** a **Comprehensive State Mental Health Plan**. • **Disparities** in Mental Health **Services** are **Eliminated**.	• Partner to **create** a set of practical performance measures for agencies that administer federal programs that have an impact on people with intellectual disabilities to hold them **accountable** for the advancement of **outcomes** that improve personal and economic freedom. These measures and performance indicators should be comprehensive, consistent, and complementary.	• Quality initiatives to focus on **best practices**. • Focus on state collections and analysis of data to be used to remediate and improve services and supports.
Cost Effective ❖Services for persons with mental illness, developmental disabilities and substance abuse problems will be cost effective and will optimize available resources.	• Focus on those policies that **maximize** the utility of **existing resources** by Increasing Cost Effectiveness and Reducing Unnecessary and Burdensome Regulatory Barriers. • Ensure **Innovative**, **Flexibility**, and **Accountability** at All Levels of Government and Respect the Constitutional Role of the States and Indian Tribes.	• Ensure **authority** over dollars needed for support. • Support to **organize resources** in ways that are life-enhancing and meaningful. • Take **responsibility** for the wise use of **public dollars.** • Commission longitudinal studies to: 1) design new financing options and assess their impact on service access and delivery to persons with intellectual disabilities.	• **Financial accountability** is assured and payments are made promptly in accordance with program requirements.

Chapter 2. Original Provisions of Reform

This chapter identifies the provisions of the reform legislation HB381 that represent the original intention and conceptual basis for transformation of the mental health, developmental disabilities and substance abuse services system. Further, it identifies the provisions from State Plan 2001 through State Plan 2005 that are still applicable. Finally, this chapter provides the means to organize and assess these provisions and to structure the remainder of the document.

Applicable Provisions from the Reform Legislation

Session Law 2001-437, HB 381 specified the provisions for reform and the contents for the State Plan for implementing reform. Appendix A provides excerpts from HB 381 and highlights provisions as key words.

The reform legislation clearly lays out the basic values and requirements for the delivery of services for the people of North Carolina who experience mental health issues, developmental disabilities and/or substance abuse problems.

The original reform legislation called for:

- A delivery system designed to **meet the needs of consumers** in the least restrictive, therapeutically most appropriate setting available and to maximize their quality of life.
- **Community-based services** when such services are appropriate, unopposed by the affected individuals, and can be reasonably accommodated within available resources, taking into account the needs of others.
- **A unified system of services** centered in area authorities or county programs and where the area authority or county program is the locus of coordination.
- A **continuum of services** for clients inclusive of area authorities, county programs, local providers and State facilities while considering the availability of services in the private sector.
- **Core services** that are available for all individuals including screening, assessment, and referral; emergency services; service coordination; and consultation, prevention, and education.
- **Targeted populations,** meaning those individuals given service priority under the State Plan.
- Services provided **within available resources.**
- Protection of the **rights of consumers**.

The Division's mission, vision and guiding principles capture the essence of these values. Each State plan published by the Division has included these statements.[4]

Vision

North Carolina residents with mental health, developmental disabilities and substance abuse service needs will have prompt access to evidence-based, culturally competent services in their communities to support them in achieving their goals in life.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.

Guiding Principles

- *Participant driven.*
- *Community based.*
- *Prevention focused.*
- *Recovery outcome oriented.*
- *Reflect best treatment/support practices.*
- *Cost effective.*

Design of the Transformed Service Delivery System

There are two fundamental requirements that underlie the design of the community-based system of services.

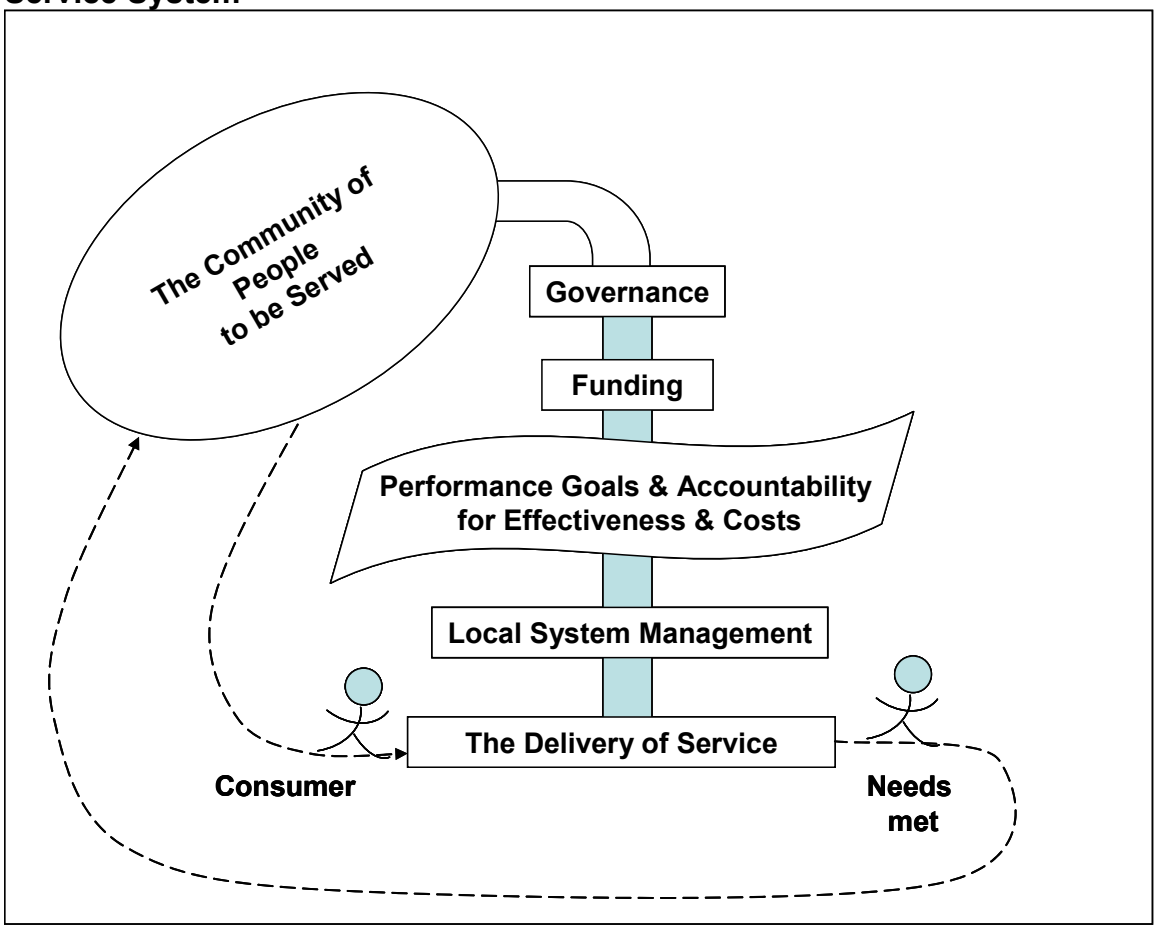
1. The system must be concerned with both effectiveness and cost.
2. The effects of the system must be specified by the community members it is intended to serve.

Given the values stated above and these two requirements, the design of the community service delivery system is concerned with six essential elements and their relationships. As shown in figure 1, these essential elements are:

- The community of people to be served.
- The governance of the system.
- Funding of the system.
- Performance goals and accountability for effectiveness and costs.
- The local management of the system.
- The delivery of services.

[4] The Division revised its Vision in July 2006 to more clearly align with the Vision and business plan of the Department of Health and Human Services.

Figure 1. Key Components of an Effective Community-Based Human Service System



Applicable Provisions from Prior State Plans

Beginning with *State Plan 2001: A Blueprint for Change*, the Division published annual State plans as cumulative documentation of the Division's interpretation and conception of the legislation and its plans to transform the old service delivery system into a community-based system. These documents contain descriptions of various parts of the system and specific tasks to be accomplished to implement the system.

The Division has conducted an analysis of these five documents, as required by House Bill 2077, which points out the complexity of the overall undertaking. This analysis is two-fold:

1. An assessment of the topics covered in the five State plans by year and cumulatively organized by the primary provisions of the reform legislation.

2. A determination of the current status of each of the detailed tasks listed in each of the five State Plans. Appendix D lists these detailed tasks and the status of each, with explanation if necessary.

Table 2 identifies the provisions that are still applicable from both the reform legislation and prior state plans. These provisions are organized according to the essential elements of the community-based service delivery system shown in figure 1.

The chapters that follow are also organized by the essential elements of a community-based system. Each chapter identifies those provisions of the legislation and prior state plans that are still applicable, provides an analysis of prior tasks and summarizes what has been accomplished over the past five years and the current status of the system.

Table 2. Primary Provisions of Reform Legislation and Prior State Plans

Elements of Community-Based System	Provisions of HB 381	Related Provisions of State Plans 2001-2005
THE COMMUNITY OF PEOPLE TO BE SERVED	**Targeted populations**	• Target populations (2001, 2002, 2003, 2004, 2005) • Summary of community needs (2002) • Child mental health plan (2004, 2005)
GOVERNANCE OF THE SYSTEM	**Area boards and county commissioners**	
	Local Consumer Advocacy Programs (Local CFAC)	• Local consumer and family advisory committees (2003) • LME-CFAC agreement (2003)
	Human rights committees	• Appeals, grievances, human rights, consumer advocacy (2002)
	Role and responsibilities of the Secretary of DHHS-the Division of Mental Health, Developmental Disabilities and Substance Abuse Services	• Infrastructure of system (2001, 2002) • National & federal policies (2002) • System transition issues (2002) • Reorganization of the Division (2002, 2003, 2004, 2005)
	State consumer advocacy programs (State CFAC)	• State CFACs (2001, 2002, 2003, 2004, 2005) • Transformation of consumer and family participation in reform (2005)
FUNDING OF THE SYSTEM	**Funding within available resources**	• Total system financing (2001) • Integrated Payment and Reporting System (2002) • Finance strategy (2002, 2004, 2005)
PERFORMANCE GOALS & ACCOUNTABILITY FOR EFFECTIVENESS & COSTS	**Administrative Rules**	• Rules & statutes (2001, 2002, 2004, 2005)
	Role and responsibilities of the Secretary of Department of Health and Human Services and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services	• Federal policies & social trends & policies (2002) • Quality management (2005) • Cultural competence (2001, 2003, 2005) • Technical assistance (2002) • Data collection & analysis (2001, 2002, 2003, 2004, 2005)

Elements of Community-Based System	Provisions of HB 381	Related Provisions of State Plans 2001-2005
		• Licensing and monitoring (2001, 2002, 2005)
THE LOCAL MANAGEMENT OF THE SYSTEM	**Roles and responsibilities of Local Management Entities (LMEs)**	• Local Management Entities (2001, 2003) • LME-provider contracts (2001, 2002, 2003, 2004, 2005) • Role and functions of LMEs (2002) • Performance contract (2002, 2005)
	LME local business plans & certification	• Local business plans, (2001, 2002, 2003, 2004, 2005) • Consolidation, certification and accreditation (2002, 2004, 2005)
	Core services	• Uniform portal (2001) • Core functions (2002, 2003, 2004, 2005) • System access (2002) • Screening, triage, referral (2001, 2002, 2003) • Prevention (2001, 2002, 2003, 2004, 2005)
THE DELIVERY OF SERVICES	**A delivery system of mental health, developmental disability and substance abuse services**	• New system design (2001) • Self-determination & Recovery (2002) • Person-centered planning (2002, 2003) • Staff competencies, education and training (2002, 2005)
	Community-based services	• Community services (2002) • Community capacity (2002, 2005) • Key system characteristics (2003) • CAP-MR/DD (2005) • LME providing direct services (2002, 2003)
	A unified system of services	• Qualified service providers (2001, 2002, 2003) • Documentation (2001, 2002) • Utilization management (2001, 2002, 2003, 2004, 2005)

Elements of Community-Based System	Provisions of HB 381	Related Provisions of State Plans 2001-2005
	A **continuum of services**	• Array of services (2001, 2002, 2004, 2005) • Assessment (2001, 2002) • Best practices (2003, 2005) • Care coordination, case management. Service coordination (2002, 2003) • Systems development (2003) • Emergency services (2001, 2002, 2003, 2005) • Crisis stabilization services (2005) • Enhanced benefits package (2005) • Justice system innovations (2005) • Employment/vocational services (2004)
	State facilities	• Downsizing (2002, 2004) • Consolidated hospital (2002, 2004) • Olmstead plan (2004) • Bed day allocation plan (2004) • Transformation of state facilities (2005) • State facility regions (2005)

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Chapter 3. The Community of People to be Served

The members of the community to be served by the public system of mental health, developmental disabilities and substance abuse services and supports must be unambiguously identified. While the primary focus of the transformed system is to provide services for individuals with the most severe disabilities and in the greatest need (defined as target populations), the community-based service system is also designed to be responsive to individuals in crisis. As required by legislation, any individual is eligible for screening and referral and for services in the event of a crisis. In addition, the community system is concerned with education and prevention of problems among its general population.

The reform legislation states that within available resources the State shall provide funding to support services to targeted populations. This means individuals with the greatest need who are eligible according to specific criteria. As legislatively directed, the Division established appropriate criteria to identify individuals with various disabilities.

Target populations were first established and described in detail in State Plan 2001 and have been included in each subsequent State Plan. These target populations are specifically described by both age (child and adult) and disability (mental health, developmental disabilities or substance abuse) and includes those populations who experience co-occurring disabilities. Estimates of the prevalence of problems for each age/disability group were first provided in State Plan 2002.

Since the beginning of reform, the Division has continuously evaluated the definitions of the target populations to assure that we respond to evolving needs in a timely way. A complete and current listing of the target populations is maintained on the Division's web site.[5]

Some changes have occurred since the original State Plan was published in November 2001.

- State Plan 2002 added target populations in each age and disability category for individuals who are deaf or hard of hearing.

- Communication Bulletin #003, dated October 28, 2002, clarified the management of resources in serving State Plan target and non-target populations during the transition.

[5] See the Division's web site for the most current description of the targeted populations at: http://www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm. Click on each age disability category for a detailed description of each.

- State Plan 2003 clarified that those individuals who are eligible for Medicaid are entitled to services whether or not they meet the specific criteria of the target populations. Those individuals who are not eligible for Medicaid must meet the specific criteria of a target population to received State-funded services. This is primarily due to the fact that services paid by State dollars are not an entitlement.

- In September 2005 the use of Child and Adolescent Functional Assessment Scale (CAFAS) was removed from the criteria for child populations when the Division elected to not upgrade to the most recent version as required by the developer.[6]

- Also in 2005, the Division expanded the definition of Substance Abuse High Management to include detoxification and consumers with stimulant disorders.

- In 2006, the Division added two target populations, the Adult Mental Health Stable Recovery population (AMSRE) and Assessment Only (AO) for each age/disability population.

- The Division is emphasizing crisis services during State fiscal year 2006-2007 and is defining a new target population for people in need of crisis services.

The Division will draft a rule to specify the criteria for defining target populations during State fiscal year 2006-2007. Once adopted, the mental health, developmental disabilities and substance abuse service system must serve individuals who currently or in the future meet those criteria within available State resources.

Regarding target populations for children, a Division workgroup studied the Child Mental Health Plan that was prepared by the Division and the State Collaborative in September 2003. This workgroup represented the needs of children and families in the Division's overall design and development of the transformed system.[7] The principles of System of Care were emphasized in this process, including the importance of child and family teams for the development and monitoring of a person-centered plan and the importance of a local community collaboratives in coordinating the services for children and their families across agencies. These efforts focused attention on identifying and serving children with severe impairments and their families.

A five-year System of Care federal grant that demonstrated the success of that approach was completed in 2006. In support of the further development and implementation of System of Care across the entire state, the Division earmarked new funds in State fiscal year 2005-2006 in each local management entity to establish one full-time equivalent staff as System of Care Coordinator to provide local community leadership, training and technical assistance. A dedicated staff member of the Division provides support to these new local positions in working with child target populations.

[6] See this announcement on the Division's web site at: http://www.dhhs.state.nc.us/mhddsas/announce/cafasdeletion-iprstargetpopcriteria9-26-05a-2.pdf

[7] See Communication Bulletin # 11: Child Mental Health Plan; and Communication Bulletin # 25: Child Mental Health Plan Implementation Update.

Efforts to work with child target populations continue through the collaboration of the Division and the Department of Public Instruction to facilitate the coordination of educational and behavioral health services for children in public schools.[8]

In addition, the Division is participating in the Governor's School-Based Child and Family Support Team initiative by providing funding to designated local management entities to hire care coordinators to work with child and family teams. The care coordinators will:

- Serve as the primary contact for the schools in their catchment area for children and families identified as having behavioral health issues.
- Receive and coordinate all school referrals for all school age children and assure that children referred are screened, assessed and connected with services and supports.
- Work with the schools, especially the social worker/school nurse teams, to discuss treatment options with the child and family and assist in connecting them to the local management entity and treatment providers, clinical home with medical home and other supports within the community System of Care.

In addition to defining new target populations in each age and disability category for people who are deaf or hard of hearing, the Division has funded the continued employment of deaf and hard of hearing specialists by local management entities (LMEs) to ensure continued support for children and adults across the State.[9]

There are numerous advocacy, consumer and professional organizations and individual advocates that work to increase the awareness of the needs of individuals with disabilities. These stakeholders represent consumers to governance and on governance bodies and bring attention to the need for system reform, for best practices and for increased funding.

[8] See "The Transition to Community Support Services for Children in Public Schools" workbook and DVD on the Division's web site: http://www.dhhs.state.nc.us/mhddsas/childandfamily/index-new.htm
[9] See Communication Bulletin # 58: Services to Consumers who are Deaf, Hard of Hearing or Deaf-Blind.

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Chapter 4. Governance of the System

Governance is the means that charts the course for the system and by which the system is held accountable for meeting the needs of people according to performance standards and available resources. In order to satisfy the requirement for accountability for effectiveness and costs and the requirement that the system be participant driven, there must be a governance body to speak for the people who are served and act on their behalf. Governing bodies set performance expectations and require that the system conform to its standards and report to it on a regular basis.

For the North Carolina statewide system, governance primarily occurs at two levels. This chapter provides the State's analysis of progress with this element of the system.

Local Level

At the local level, governance is provided by an area board and county commissioners with advice and input from the local consumer and family advisory committee (CFAC) and the local human rights committee.

County Commissioners and Area Boards

North Carolina's Session Law 2001-437 and Session Law 2006-142 speak directly to the structure and duties and responsibilities of counties and area boards with regard to the public mental health, developmental disabilities and substance abuse service system. Briefly, legislation requires that counties appropriate funds to support local programs and specifies the structure and organization of area boards and responsibilities for finance.

Local Consumer and Family Advisory Committees

Legislation also calls for the formation and operation of local consumer and family advisory committees (CFACs) and specifies their roles and responsibilities. These are self-governing and self-directed organizations that advise the local management of the system regarding the planning and management of the local public mental health, developmental disabilities and substance abuse service system. At the request of either one, the local governing board or the local consumer and family advisory committee may execute an agreement that identifies their roles and responsibilities, channels of communication between them and a process for resolving disputes.

In order to address the consumer involvement requirements of HB 381, the initial State Plan directed each LME to create a consumer and family advisory committee (CFAC).[10] The consumer and family advisory committee, comprised of adult consumers and family

[10] See the Division's Communication Bulletin #031 entitled "LME/CFAC Relational Agreement."

members, is to advise the LME. During the last four years local consumer and family advisory committees have been established and operational for every local management entity.

As specified in Session Law 2006-142, House Bill 2077, Section 5, a consumer and family advisory committee's duties include:

- Reviewing, commenting on and monitoring the implementation of the local business plan.
- Identifying service gaps and underserved populations.
- Making recommendations regarding the service array and monitoring the development of additional services.
- Reviewing and commenting on the area authority or county program budget.
- Participating in all quality improvement measures and performance indicators.
- Submitting to the State consumer and family advisory committee their findings and recommendations regarding ways to improve the delivery of mental health, developmental disabilities and substance abuse services.

Human Rights Committees

Session Law 2001-437, House Bill 381, Section 1.3 requires the establishment of human rights committees at each State facility and for each area authority and county program. Rules specify the duties of these committees. Area authorities and county programs as local management entities oversee consumer rights for their catchment areas. In addition, providers who use restrictive interventions must have an Intervention Advisory Committee to review the interventions as required by statute 10A NCAC 27E.0106.

State Level

At the State level, the North Carolina General Assembly serves to represent and speak for communities and residents of the State including the people served by the public mental health, developmental disabilities and substance abuse services system. Reform of the MH/DD/SA services system was initiated by the General Assembly with Session Law 2001-437. The General Assembly established the Legislative Oversight Committee to which the Department and Division report on a quarterly basis on progress of reform.[11]

The Department of Health and Human Services and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services

The Secretary of the Department of Health and Human Services and its Division of Mental Health, Developmental Disabilities and Substance Abuse Services are responsible for administering and enforcing the reform statute and other statutes related to the public

[11]The quarterly reports to the Legislative Oversight Committee can be found on the Division's web site. See http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/index.htm

mental health, developmental disabilities and substance abuse services system. In addition to the development of policy guidance and provision of technical assistance, the development and adoption of rules is a primary means for carrying out this responsibility. In addition to rules, the State is bound by federal regulations (such as the Code of Federal Regulations 42CFR that speaks to confidentiality) and federal funding requirements (such as those from the Substance Abuse and Mental Health Services Administration and the Centers of Medicare and Medicaid) to which the Department and the Division must ensure that the system adheres. The federal government sets an agenda and provides major funding for services through block grants and Medicaid. The State must follow guidelines to qualify and utilize these funds.

One of the first steps taken by the Division following the passage of HB381 was to meet with the North Carolina Association of County Commissioners to discuss and clarify the intentions and implications for change activated by the reform legislation. Division leadership conducted town hall meetings and broadcast videoconferences across the State to increase public awareness of the goals and impact of reform. These vehicles enabled the Division to communicate new developments related to reform and to hear the concerns of consumers and their families and other stakeholders.

Another method of communication is the rights and empowerment conference for consumers held by the Division each year. During 2006 this conference focused on the power of change and sessions addressed accessing services, choice of providers, protection of rights and advocacy.

In addition, the Division implemented a series of communication bulletins in 2002 and enhanced services implementation updates in 2006 to provide policy and technical guidance to local governance and management of services. References to such applicable communications are made throughout this document. The Division's web site has recently been enhanced to increase access to publications and documents by consumers and families, providers, governance and management. All announcements, communication bulletins, implementation updates and other materials related to reform are available on the Division's web site.

In order to carry out its responsibilities for the transformation and operation of mental health, developmental disabilities and substance abuse services, the Division collaborates with other divisions of the Department of Health and Human Services such as the Division of Social Services, Division of Public Health, Division of Medical Assistance and the Division of Facility Services, and with other departments of State government such as the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction. Since 2001, the Division has renewed interagency memoranda of agreement and developed new agreements and procedures with these state agencies to facilitate operations at the local level.

The Division has worked closely with the Division of Medical Assistance to develop the new enhanced service definitions and the new Community Alternative Program for Developmental Disabilities (often referred to as the CAP-MR/DD waiver). In addition,

the two divisions have collaborated in the enrollment of providers of services in the Medicaid system. The Division has worked closely with the Division of Facility Services to coordinate oversight activities of licensed facilities.

The Department and the Division are responsible for reporting progress to the Legislative Oversight Committee of the General Assembly. Local management is responsible for reporting to its local governance bodies as well as to the Division.

State Consumer and Family Advisory Committee

Session Law 2001-437 and Session Law 2006-142 also required the establishment of a State Consumer and Family Advisory Committee (CFAC) to advise the Department, the Division and the General Assembly on the planning and management of the State's public mental health, developmental disabilities and substance abuse services system.

The Division's Communication Bulletin #059 noted that both the State and local consumer and family advisory committees are now codified in statute. The fact that State and local consumer and family advisory committees are now in statute speaks to North Carolina's commitment to and regard for the perspective of consumers and family members in the mental health, developmental disabilities and substance abuse service system.

The first meeting of the State Consumer and Family Advisory Committee was May 5, 2004. The Division is currently working to implement changes as they relate to the State Consumer and Family Advisory Committee in order to accommodate the requirements outlined in the 2006 statute. The Division will provide assistance to the local consumer and family advisory committees as far as any changes they may need to make given the new statutory guidelines.

Chapter 5. Funding of the System

An effective public mental health, developmental disabilities and substance abuse services system requires a true partnership among consumers, family members, local management entities, providers, counties and the State and federal governments. As the major financing source for the public system, the State, federal government and counties have a responsibility to support the provision of services to individuals with, or ask risk of, mental illness, developmental disabilities and substance abuse problems.

Concurrently, these entities have the fiduciary responsibility to ensure that public funds that they appropriate are utilized in a cost effective manner to support positive outcomes for consumers. As local managers of the public mental health, developmental disabilities and substance abuse services system, local management entities play a critical role in ensuring a partnership among stakeholders and as the focal point for local financial management and accountability.

With finite resources, it is recognized that State-funded services must be provided within available resources. In State fiscal year 2007, the Division receives over $650,000,000 in State funds on a recurring basis for State-funded institution and community-based services, as compared to approximately $593.8 million in State fiscal year 2006. However, additional resources are needed to meet the needs of all consumers who are not eligible for Medicaid or Health Choice or do not have third party insurance coverage. While all resources must be appropriately managed, local management entities have a unique role and challenge in managing limited State and county funds to address the needs of their local residents.

Since the majority of funding (61 percent or $1.42 billion) for the public mental health, developmental disabilities and substance abuse service system is derived from Medicaid receipts, the Division works collaboratively with the Division of Medical Assistance to assure that services provided are approved by the federal Centers of Medicare and Medicaid. Likewise, Health Choice is a system of insurance funding for children of North Carolina who are not covered by insurance.

In addition to efforts to increase Medicaid receipts and additional funding made available by the North Carolina General Assembly, funding is being shifted from State facilities to increase community service capacity as State facilities are downsized. Between State fiscal year 2002 and State fiscal year 2006, State facilities eliminated 413.25 positions and related operating cost, with over $15.5 million in State appropriations transferred from State facilities to funding for community-based services. An additional $1.1 million in Medicaid receipts have been realigned within the Division of Medical Assistance's budget from State institution funding to support services provided via the community-based Community Alternative Program for Developmental Disabilities (CAP-MR/DD) wavier.

The General Assembly also appropriated over $105,000,000 for the Mental Health Trust Fund to support implementation of system transformation and increasing community-based service capacity. In addition, the State General Assembly has designated non-recurring funds for hiring consultants to assist DHHS and the Division with specific tasks during State fiscal years 2007 and 2008.

Finance Strategy

In order to ensure that a financing strategy for the public mental health, developmental disabilities and substance abuse services system is in place to effectively address needs and resources, the Division has undertaken a comprehensive assessment of service needs, service resources, service gaps and cost modeling. These efforts are closely linked through two initiatives initiated in SFY 06.

First, the Division issued a competitively bid contract for the development of a long range planning model that will predict the overall cost of services needed at the community level. The long range planning model is based on assumptions associated with movement to evidence based practices and provides information regarding service needs, current service resources, identification of service gaps and service constructs that focus on positive consumer outcomes.

Secondly, the Division awarded another competitively bid contract to develop a funding cost model for services. This model factors in variables such as the number of Medicaid eligible and non-eligible consumers, current penetration rates for Medicaid and non-Medicaid consumers, available resources and potential earning capacity for additional resources. Once service costs are estimated by the long range planning model, the costs of such services will be entered into the finance model.

The finance model will render estimates of additional Medicaid resources that may be earned, availability of county funds and funding needs for non-Medicaid consumers or non-Medicaid covered services. This information will assist the Division in allocating existing State resources on an equitable basis to help ensure the availability of services in all communities throughout the State. It will also provide, in a quantifiable manner, additional resources that would be needed to achieve varying levels of evidence based practices implementation.

Both models described above will be delivered to the Division in State fiscal year 2007 and will be operational in State fiscal year 2008 for use in determining funding needs and resource distribution.

Another key element for improvement in the overall finance strategy for the public mental health, developmental disabilities and substance abuse system is the continued refinement and updating of service definitions. Effective March 20, 2006, the federal Centers for Medicare and Medicaid Services approved an array of new and improved Medicaid service definitions that the Division considered a critical milestone in overall

system transformation. Approval of these services by the Centers for Medicare and Medicaid Services, coupled with the new Community Alternatives Program waiver that was effective September 1, 2005, provides the clinical foundation for transforming the community service array and providing more effective services to consumers. Each of these initiatives is included within the overall financing strategies described above.

Standardization

In response to action taken by the General Assembly and in concert with activities currently being conducted by the Division, the Division is pursuing a Request for Proposals in State fiscal year 2007 that, among other activities, will focus on the standardization of forms, contracts, processes and procedures at the local level. Standardization of functions and processes will aid providers by creating a relatively uniform business environment, regardless of which area authority or county program the provider contracts with for the provision of services. This will in turn, and more importantly, benefit consumers and family members by contributing to the development and stabilization of community-based resources provided by a wide array of providers throughout the State. Activities to be addressed in this process to improve standardization include, but are not limited to, the following:

- Standard Forms - Consideration of the standardization of forms required of providers by area authorities or county programs.

- Standard Contracts - Review of current standard contract content for Medicaid and State-funded services currently in place for any recommended improvements.

- Standard Processes and Procedures – Assessment of local functions associated with the provider monitoring for the standardization of processes and procedures.

- Standard Denial Codes – Consideration of standardized denial codes at the local level prior to service units being billed to Medicaid or the Division's Integrated Payment and Reporting System (known as IPRS).

- Coordination of Benefits – More effective procedures for the coordination of benefits to optimize resources at the local level.

- Standard Definition of a "Clean Claim" - Ensure a standardized definition and process among local management entities and providers in determining a "clean claim".

- Area Authority and County Program Management Information Systems - Assessment and potential changes of local management information systems in order to improve the delivery of services to consumers and family members through a more effective methodology for securing and accessing information.

- Feasibility of a Standard Electronic Health Record - The Division's strategic vision includes continuity of care across all settings, including the community and State facilities.

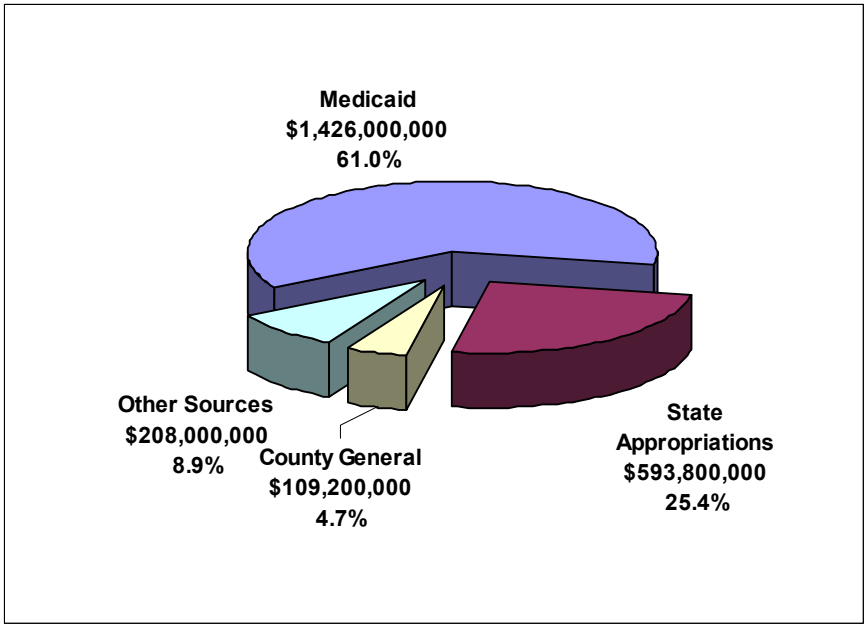
Total Public Mental Health, Developmental Disabilities and Substance Abuse Services System Funding

During State fiscal year 2006, total funding within the public service system was approximately $2.3 billion dollars, inclusive of all funding sources for the Division's State operated facilities, community-based services and the Division's central administration.[12]

At a summary level, total system funding is illustrated in figures 2 and 3 below. In figure 2, note that Medicaid funds include federal dollars plus State and county shares. Other sources of funds include block grants, Medicare, first party payments, insurance payments and other grants.

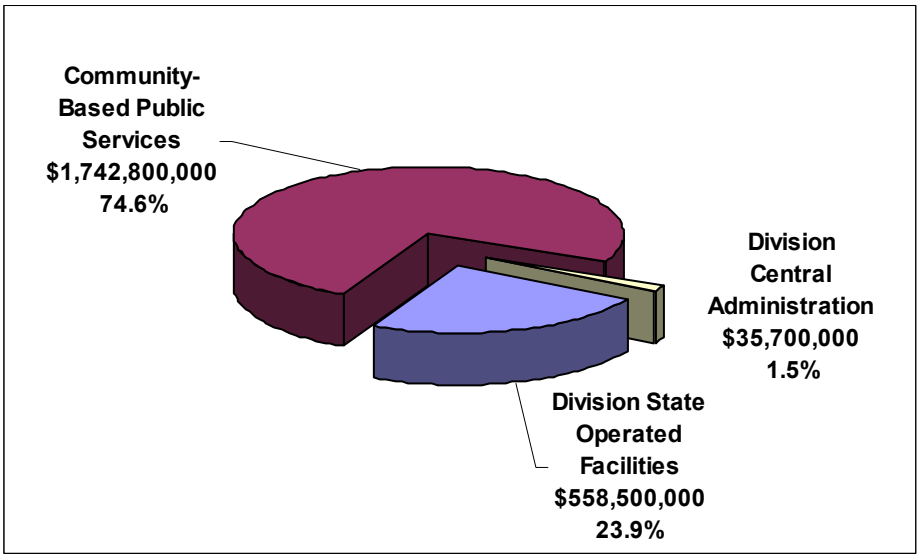
In figure 3, note that Division central administration includes the operation of the Integrated Payment and Reporting System (IPRS) for the community based State-funded services.

Figure 2. SFY 2006 Sources of Funding of the Public MH/DD/SAS System



[12] Community-based services include intermediate care facilities for mentally retarded known as ICF-MR and the Community Alternative Program for Developmental Disabilities known as CAP-MR/DD.

Figure 3. SFY 2006 Funding of the Public MH/DD/SAS System by Setting



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Chapter 6. Performance Goals and Accountability for Effectiveness and Costs

The primary goal of the community-based system is to provide effective mental health, developmental disabilities and substance abuse services and supports. Effective means that the services and supports produce the desired outcomes for individuals using best practices within the resources available. Achievement of this goal requires setting performance standards and measuring progress on a regular basis. This provides a feedback loop to for continuous improvement of the system.

There are two types of performance goals: (1) outcomes for individuals served by the system, and (2) measures of how well the system is operating on an ongoing basis. By setting performance goals and monitoring progress, adjustments can be made over time to increase the quality of the service system.

Using person-centered thinking, outcomes for consumers focus on what is important *to* the consumer, such as recovery, health, independence, community inclusion, safety, social support, housing, employment, daily activities and justice. System performance goals focus on what is important *for* the consumer, such as use of best practice models of care, person-centered planning, ease of access, choice of quality providers and continuous improvement of services.

The first semi-annual Statewide System Performance Report for SFY 2006-2007 published October 2006 provides progress in both consumer outcomes and system performance. See the Division's web site for a copy of this report.[13]

Effective Outcomes for Consumers and their Families

On a personal level, consumer outcomes are tied to the goals of each consumer's person-centered plan. These goals are defined by the individual and family members with the assistance of the professional staff of the system and written in the consumer's person-centered plan. Assessment of progress toward those goals is made by those same people on a periodic basis. Success depends on the participation of the consumer and the quality of the professional services and supports provided. See the discussion of person-centered planning in chapter 8.

[13] See the Division's web site at: http://www.dhhs.state.nc.us/mhddsas/.

On an aggregate level, consumer outcomes are defined by domains that are important to all individuals to enable control over one's life, such as:

- Safe stable housing.
- Meaningful daily activities.
- Justice.
- Respectful inclusion in a community of choice.
- Supportive relationships.
- Emotional well-being.
- Employment.
- Freedom from addiction and disruptive symptoms.

Such outcomes are identified by the State so it can determine how well all consumers are being served by the system. These outcomes are based on the National Outcome Measures being developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Quality Framework developed by the federal Centers for Medicare and Medicaid Services. (Both of these are addressed in table 1.) Such consumer outcomes enable the State to assess the success of its service delivery system in comparison with other states and with national standards.

Outcomes for consumers with diagnoses of mental illness and/or substance abuse are measured by the North Carolina Treatment Outcomes Program Performance System (NC-TOPPS). This system, initially implemented in 1995, was expanded in July 2005 to include all mental health and substance abuse consumers ages six and above.[14] Initial data show that mental health and substance abuse consumers show marked improvement in a variety of areas after three months of treatment.

Outcomes for consumers with a developmental disability are measured through the National Core Indicator Project. The national reports prepared by the Human Services Research Institute (HSRI) compare the data from participating states.[15] North Carolina participates in the project through interviews with a sample of consumers and surveys of parents and guardians. Overall, North Carolina performs as well as or better than other states in measures for consumers with developmental disabilities' participation in community life and meaningful activities.

Consumers' perceptions of their progress toward personal goals and the quality of the services they receive are critical barometers of the effectiveness of the service system. National Core Indicators Project surveys provide consumers and family members' views for evaluating service quality. For consumers of mental health and substance abuse services, the State uses the Consumer Survey developed by the national Mental Health Statistical Improvement Project (MHSIP) and sponsored by SAMHSA.[16] Both of these surveys allow rough comparisons to other states, in which North Carolina generally performs similarly to national averages.

[14] A report of results for SFY 2005-2006 NC-TOPPS can be found at the following web site: http://www.ndri-nc.org/nc-topps_research_feedback.htm#0506

[15] More information about Core Indicators is available at: http://www.hsri.org/nci/index.asp?id=reports.

[16] See the annual consumer satisfaction reports for State fiscal years 2000 through 2003 on the Division's web site at: http://www.dhhs.state.nc.us/mhddsas/statspublications/reports/index.htm

System Performance

Achievement of consumer outcomes depends on a service system that is operating with optimal efficiency and effectiveness.

Quality Management

System performance and service outcomes are basically quality management issues. Attention to quality must be integrated throughout the entire system with the participation of all stakeholders in designated roles. Quality management at all levels of the system includes specification of desired outcomes, identification of outcome indicators and measures, monitoring of service provision, development of measurement tools, data collection, periodic reporting of progress on key indicators of quality, review of information by management staff for decision making, evaluation of system performance, and use of data for focusing quality improvement efforts and quality assurance plans.

Performance standards of the system are based on:

- Federal and State statutes, rules, regulations, licensing and policies.
- Memoranda of understanding and contracts among State agencies.
- Requirements of national performance expectations.
- Goals of State reform.

System performance includes such issues as how quickly and effectively the local system responds to the needs of people, how well the system is managed and how well it meets quality standards. For example, how well does the system respond:

- When an individual calls for the first time.
- When a consumer is experiencing a crisis.
- To develop a person-centered plan.
- To stay within available resources.
- To develop needed service capacity.
- With fidelity to best practices.
- To protect safety and rights.

The DHHS – LME Performance Contract

Performance standards for local system operations are contained in the performance based contract between the State and the local management of the system. In 1999, the performance contract process replaced the annual memorandum of agreement that was signed by each area authority/county program and the Division. This change demonstrated the Division's focus on greater accountability for effectiveness and funding invested in the system by the General Assembly and the federal government.

The process encourages a business relationship between the Division and local management entities by outlining specific requirements geared toward major program

outcomes and standards for operations. The Division routinely monitors area authority/county program's fulfillment of the performance requirements. The current performance contract includes requirements for:

- General administration and governance.
- Access, triage and referral.
- Service management.
- Provider relations and support.
- Customer services and consumer rights.
- Quality management and outcomes evaluation.
- Business management and accounting.
- Information management, analysis and reporting.

The Division publishes quarterly reports showing the progress of area authorities/county programs in satisfying the requirements.[17] In November 2006, the Division will publish the first quarterly report on key indicators of local performance.

Long-Term System Goals

The Division may also set long-term goals for system operation or outcomes. By definition these are goals that cannot be accomplished in one or two years. Such goals may focus on implementation of aspects of the transformed system, such as downsizing the state facilities. Long-term goals may also be based on broad consumer outcomes such as reducing the number of children who start smoking cigarettes.

Ultimately, long-term goals focus on the overall impact the service system has on the personal lives of children, families and adults. Further, these outcomes have an impact on the health and safety of their communities and on the health of the state.

Service Monitoring

System reform allows for a local and State partnership for monitoring the quality and appropriateness of mental health, developmental disabilities and substance abuse services through regular monitoring visits, review of critical incident reports and the aggregation of statewide data for trend analysis. Staff of the Division are responsible for performing independent complaint investigations and monitoring of all components of the public mental health, developmental disabilities and substance abuse services system. Local management entities are responsible for monitoring service providers in their catchment area. This monitoring – local and State – serves to assure that the funding appropriated for mental health, developmental disabilities and substance abuse services and supports is spent appropriately, and that consumers of services receive the highest quality care, in the most appropriate setting and in accordance with best practice.

[17] Performance contract and quarterly progress reports can be seen on the Division's web site at: http://www.dhhs.state.nc.us/mhddsas/performanceagreement/index.htm

Public accountability is embedded in the overall system reform process – from initial planning for service delivery and administration through the actual delivery of services, follow up, monitoring and contracting. As the system has evolved, a clear and unbroken "chain of accountability" has emerged. This involves a public partner relationship between the leadership, support and oversight role of the State system and the management of public policy role of the local public system. In turn, a public-private partnership emerges between the local management of the system and providers of services. Additionally, the system continues to develop a more effective and efficient set of regulatory compliance requirements as system performance and consumer outcomes act as critical drivers of improvement efforts.

The specification of performance standards provides a clear direction for system operations year after year. Further, clear measures of performance must be specified as part of the standards. These measures must be included in the performance-based contracts between the State and local management entities and between a local management entity and providers of services. The measures allow the means for recognizing how far the public mental health, developmental disabilities and substance abuse services system has come and where it needs to go next.

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Chapter 7. The Local Management of the System

This element of the system provides for a single point of accountability for the performance of the system at the local level. In the North Carolina system, the area authority or county program[18] must be certified by the Secretary of the Department of Health and Human Services to perform as a local management entity. The reform legislation obligated each county to decide on the form of local governance for management of mental health, developmental disabilities and substance abuse services. While a county can be part of an area authority, a single county program, or part of an inter-local agreement, the function of these organizations as local management entities is the same. Once established and certified, each public program is referred to as a local management entity or LME – a collective term that refers to the purpose and functional responsibilities of the public agency rather than describing its governance structure.

In HB 381, area authorities and county programs were directed to become local management entities. Public services previously delivered directly by area authorities or county programs were to be divested to private providers. As the system transformation has progressed, it has been discerned that certain services are at times most efficiently and effectively delivered by the local management entity. In these cases, local management entities have returned to the provision of a narrow range of discreet services such as psychiatric care. In addition, legislation allows that an area authority or county program may relinquish its local management entity functional responsibilities and contract to provide services as long as that public program meets all provider qualifications and fair competition is practiced by the local management entity.[19]

In managing services, local management entities are expected to perform a series of functions sometimes not previously expected of the area authorities and county programs. These responsibilities include, but are not limited to:

- Ensuring access, screening, triage and referral through a uniform portal of entry.
- Utilization review and management.
- Increased monitoring of services and providers.
- Understanding community-based services and supports, as well as identifying service gaps.
- Recruiting and endorsing as well as contracting with providers.
- Establishing, supporting and working with a local Consumer and Family Advisory Committee.

[18] General Statute 122C-3 defines "area authority" as the area mental health, developmental disabilities and substance abuse authority. A "county program" means a mental health, developmental disabilities and substance abuse services program established, operated and governed by a county pursuant to G.S. 122C-115.1.

[19] See article 20 of NCGS 160A.

The original State Plan 2001 contemplated full transformation to the system of local management entities by July 1, 2003. Currently, the number of area and county authorities has been reduced from 39 to 30 local management entities. In addition, each area authority or county program must respond to the requirements of its governance bodies.

Local Business Plans (LBP)

In order to achieve the transformation from service provider to management of services, the State Plan established a process and schedule for certifying newly created local management entities (LMEs). This process included the statutory requirement that counties develop local business plans for implementing and managing the transformed community behavioral healthcare system. The local business plan describes characteristics of the local management entity's catchment area, including the client base and service gaps, as well as addressing specific implementation of local management entity functions.[20]

The Secretary of the Department is responsible for the approval (or disapproval) of each three-year local business plan and certifying each local management entity. Once certified, the local management entity has a relationship that is legally formed through a performance-based contract between the Department of Health and Human Services and the local management entity. The local management entities submit to the Division quarterly progress reports about their local business plans. In addition to addressing the targets of its local business plan, the local management entity must indicate actions taken in response to the Division's communication bulletins.

The Division is currently in the process of developing the format and content requirements of a revised three-year local business plan template. This template will specify the functions and activities of each local management entity for which the Division will provide funding. Each local management entity must develop their revised plan based on this template and submit it to the Secretary of the Department by March 31, 2007 for implementation on July 1, 2007.

The DHHS - LME Performance Contract

During State fiscal year 2005, the Department of Health and Human Services (including its divisions of Mental Health, Developmental Disabilities and Substance Abuse Services, Medical Assistance and the Office of the Controller), the N.C. Council of Community Program and the N.C. Association of County Commissioners (NCACC) negotiated a

[20] See the Division's Communication Bulletin #002 entitled "Local Business Plan Submission and LME Certification" and Communication Bulleting #004 entitled "Housing Resource Development and Local Business Plans."

statewide performance contact between the Department and the LMEs.[21] This contract, which is anticipated to develop over time, currently contains each local management entity's local business plan as the scope of work, statewide requirements, performance measures and financing requirements. Division staff worked with each local management entity to incorporate its local business plan into the final contract and secure signatures. While the contract did not address all issues that various stakeholders wished to see included, the Department and local management entities are committed to working on a development plan that will add requirements to the contract over the next several years as local management entities continue to transition to their role of managers of service and public policy at the local level.

Core Functions of a Local Management Entity

General Statute 122C-115.4 defines the primary functions of a local management entity to be:

- Access for all citizens to core services, including 24/7/365 screening, triage and referral process and a uniform portal of entry into care.
- Provider endorsement, monitoring, technical assistance, capacity development and quality control.
- Utilization management/review and determination of the appropriate level and intensity of services, including review and approval of person-centered plans for consumers who receive State-funded services and concurrent review of person-centered plans for consumers who receive Medicaid funded services.
- Authorization of the utilization of State operated services and authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.
- Care coordination and quality management including the direct monitoring of the effectiveness of person-centered plans.
- Community collaboration and consumer affairs, including a process to protect consumer rights, an appeals process and support of an effective consumer and family advisory committee.[22]
- Financial management/accountability for the use of State and local funds and information management for the delivery of publicly funded services.

Session Law 2006-66, Senate Bill 1741, Section 10.32.(a) states that the Department of Health and Human Services shall allocate funds to LMEs to implement the functions described above.

Access, provider endorsement and utilization review are described in the following sections. The review and monitoring of person-centered plans is discussed in chapter 8.

[21] See Division's Communication Bulletin #023 DHHS/LME Contract.
[22] See the Division's Communication Bulletin #038 (FINAL) "Policy for Consumer Complaints to Area/County Programs."

Access, Uniform Portal, Screening, Triage and Referral

A critical component of the system reform effort includes establishing statewide consistency regarding access to services.

Access is the method(s) through which individuals can enter a health care delivery system. The probability of an individual's entry into the health care system is influenced by the structure of the delivery system itself and the nature of the potential consumer's wants, resources and needs.

Uniform portal is a term used to describe a set of standardized processes and procedures that ensures that people throughout the state are provided consistent access. The pathways to access (screening, triage, referral, and emergency services) provide the framework for uniform portal activities. There are many access points in a community; however, standards must be consistent. The concept of "no wrong door" establishes the expectation that people are able to directly enter the mental health, developmental disabilities and substance abuse services system through different access points using the same process of screening, triage and referral.

Screening is a brief standardized appraisal of an individual who is not currently being served within the system in order to determine:

- The nature of the individual's problem (that is whether the individual has a mental health, developmental disability or substance abuse need).
- The individual's level of need for services and supports.

The screening process is not an evaluation or assessment. It is a structured interview conducted by a qualified professional either face-to-face or by telephone. During the interview the process determines provisionally whether the individual may meet the criteria for a target population and where and how the individual should enter the system. Basic financial and clinical information is gathered to determine the types of benefits for which the individual qualifies.

Triage is the process for determining the level of the person's need (that is if it is emergent, urgent or routine).

Referral is the procedure by which the screening professional and the consumer choose a clinically appropriate provider and facilitate the consumer's successful contact with that provider so that services can be initiated.

The Division is currently implementing a standardized screening, triage and referral (STR) process that is used whether the individual first contacted the local management entity, a service provider or another agency. The service need, array of services and a list of potential providers are discussed with the individual so that a referral can be made to a service provider of the individual's choice.[23]

[23] See the Division's Enhanced Services Implementation Update # 014 entitled "Uniform Screening and Registration."

One of the advantages of having a standardized system is to help create a statewide database system that will be able to track services requested, services received and service gaps. Such a statewide data system can reduce duplication of effort in the information gathering and tracking process. Another significant benefit is minimizing the number of times that an individual needs to provide personal information.

Historically, access to the service system was not readily available 24-hours-a-day, seven-days-a-week (24/7/365) in all areas of the State. Much progress has been made over the last five years to ensure that access to services is standardized, reasonable, culturally sensitive and available 24-hours-a-day, seven-days-a-week through access and/or crisis phone lines or face-to-face.

Ultimately, the Division intends to:

- Continue to design and shape the statewide system of uniform portal (standardized process of access to services).
- Monitor and strengthen access system performance indicators included in the quality management system for statewide reporting.
- Refine reporting procedures regarding access – access reporting received quarterly and reported on statewide tracking reports.
- Develop and issue periodic contract performance reports.

Endorsement of Providers

During SFY 05-06, a standardized process for endorsement of all providers of Medicaid covered enhanced benefit services was implemented.[24] The purpose of this endorsement process is to assure that individuals receive services and supports from provider organizations that comply with State and federal laws and regulations and provide services in a manner consistent with the Division's reform plan and the State Medicaid Plan.

The endorsement process provides local management entities with objective criteria to determine the competency and quality of providers of approved Medicaid services. Endorsement by a local management entity and enrollment by the Division of Medical Assistance as a Medicaid provider is carried out on a service and site specific basis. The

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[24] See Communication Bulletin # 37: Provider Endorsement; Communication Bulletin # 44: Final Policy-Provider Endorsement; and Communication Bulletin # 47: Provider Endorsement Transition Plan; Communication Bulletin # 49: Letter of Support (Providers applying for licensure for a residential facility are required to seek a letter of support form the LME); Communication Bulletin # 55: New Phases for Provider Endorsement: Policy Amendment for Conditional Endorsement; Enhanced Services Implementation Update Memo # 1: CMS approval of Medicaid State Plan Amendment (SPA) to implement the Enhanced Benefit Services proposed under the Rehabilitation Option. (Provider Endorsement); Enhanced Services Implementation Update Memo # 6: Consumers' Choice of Providers, Subcontracting, Caseload Ratios, & Questions and Answers.

process is required for all enhanced benefit services prior to a provider being directly enrolled in the Medicaid program through the Division of Medical Assistance.

As of June 20, 2006 the services of a total of 1,515 providers had been endorsed and directly enrolled with Medicaid as required.

Utilization Management for State funds

A significant component of North Carolina's mental health, developmental disabilities and substance abuse services system is the process to regulate the provision of services in relation to the capacity of the system and the needs of consumers. The system's overall strategy for managing service use by individuals and by the system as a whole was described in State Plan 2003 as including the functions of:

- Eligibility determination.
- Medical necessity.
- Person-centered plan authorization.
- Utilization review.

This process ensures that services are necessary, appropriate and cost effective through pre-authorization of services for individuals, evaluation of the need for continued services and extended authorization as determined by that evaluation.[25] State Plan 2005 clarified that the process is intended to guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. It is typically an externally imposed process based on clinically defined criteria.

Such a decision-making process requires standards and criteria to ensure the most efficient and effective use of finite resources. From the beginning of reform, the Division's intention has been to provide State-defined standards and criteria for utilization review and service authorization.

Standardized criteria fall into three categories: Medicaid funded services, state funded services and utilization of the state psychiatric hospitals and other state facilities.

- Criteria are specified in the State Medicaid Plan as part of the definition of each Medicaid funded service. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance developed new and revised service definitions that are based on best practice and evidence based approaches to address the needs of consumers. These definitions were approved by the federal Centers for Medicare and Medicaid Services in December 2005 and became effective in March 20, 2006. Each definition specifies utilization criteria including entrance and continued stay criteria and provides information about the frequency or intensity of service that has been shown to lead to positive outcomes.

[25] See the Division's Enhanced Services Implementation Update #11, "Utilization Review."

The two divisions continue to work together to manage the utilization of Medicaid funds.

- The Division is developing criteria for State-funded services with the assistance of a consultant to be finalized during State fiscal year 2007. The Division will ensure that State-funded services are defined in a way that is consistent with the State Medicaid Plan and best practices.[26]

- State Plan 2003 stated that utilization of the four state psychiatric hospitals would be determined based upon a Division approved bed day allocation plan. Through this plan, bed days would be allocated to each local management entity in the following categories: adult admissions, adult long-term, geriatric admissions and adolescent admissions. Each local management entity's initial bed day allocation was based on its historical utilization during State fiscal years 2000 - 2002. State Plan 2004 implemented a revised bed day allocation stating that over the following three years, the number of bed days allocated for psychiatric beds tracks the downsizing schedule, so that fewer bed days are available after closure of beds at the end of the previous year. In addition, the basis for allocation of bed days changed from historical utilization to the population of the local management entity.

Accreditation of Local Management Entities

Both local management entities and providers of mental health, developmental disabilities and substance abuse services are being required to achieve national accreditation by established accreditation agencies known for values and standards that support the direction of mental health, developmental disabilities and substance abuse services reform.[27] The requirement for national accreditation of local management entities has been in place since the current State and local management entity performance contract went into effect.

The accreditation required of local management entities is different from the accreditation that was required of the area authority/county programs under the mental health, developmental disabilities and substance abuse services system prior to reform. The previous accreditation required was based on the role of area authorities and county programs as service providers rather than the current role as system managers.

[26] See the Division's Communication Bulletin #54 Standardized contract for State-funded Services, Guidance on Provider Billing requirements and Excel Billing Format.

[27] See the Division's Communication Bulletin #036 entitled "Approved List of Organizations Who (a) May Accredit Providers of MH/DD/SA Services, and (b) May Accredit LMEs for System Management", and Communication Bulletin #050, entitled "Approved List of Agencies Who (a) May Accredit Providers of MH/DD/SA Services, and (b) May Accredit LMEs for System Management".

Accreditation required under reform is intended to assure the State that the local management entity is qualified as a systems manager. Rules are being written that will establish this requirement in administrative code.

The requirement for national accreditation for providers of mental health, developmental disabilities and substance abuse services is established currently in the individual service definitions for the services that they provide.

Building Community Capacity

Key strategies for funding the development of community capacity include the downsizing of institutions and the transfer of institutional funding to the community. In order to successfully implement the downsizing plan for the psychiatric hospitals, the Division works with local management entities to develop sufficient community capacity to serve long-term residents of the hospitals. In addition, the Division is currently focused on transitioning residents to the community based on Olmstead plans.[28]

In building community capacity, a key element is housing. Expanding the availability of decent, safe and affordable housing for persons with mental illness, developmental disabilities and/or substance use disorders is an area where it is necessary to target resources – staff time, technical expertise and investment.[29]

Where individuals live is not an issue that can be addressed in isolation. It is directly related to the service system's capacity to provide the depth and range of community based services needed to support persons with disabilities in the community. The housing needs of consumers of mental health, developmental disabilities and substance abuse services must be addressed with a range of housing and residential models. The pure supportive housing model with scattered sites and independent units with access to flexible support services tailored to individual needs and preferences is a recognized model of best practice.

As described in chapter 5, the Division has contracted for the development of a long-term planning model that identifies gaps in services capacity and assesses alternative strategies for building capacity in the State. A final report will be presented to the Legislative Oversight Committee in December 2006.

Provider Action Agenda

In the fall of 2005, the Division Director initiated an accelerated focus on the provider system with an invitation to all providers to complete a web-based survey on the challenges facing them. Over 500 providers responded. The survey was followed up

[28] See the Division's Communication Bulletin #026 entitled "Draft 1915(c) Home and Community Based Waiver."
[29] See Communication Bulletin #004 Housing Resource Development and Local Business Plans.

with two provider summits that enabled discussion between Division management and providers about the primary themes identified from the survey.

As a result, the Division has established a Provider Action Agenda Committee with the overall goal to strengthen and enhance the provider community for the direct benefit to individuals and families who receive services. The committee has three primary objectives:

- Standardization - The identification of additional areas of needed standardization.
- Regulations and Reporting - An inventory of potentially overlapping regulation and reporting requirements.
- Provider Improvement - Collaboration and support for provider initiatives such as provider fairs, small business technical assistance and identification of training needs.

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Chapter 8. The Delivery of Services

Service delivery is the means by which the needs of people are met. The reform legislation clearly states expectations for the delivery of mental health, developmental disabilities and substance abuse services. It requires a continuum of services that is:

- Community-based.
- Regional as needed.
- Based on best practices.
- Recovery oriented.
- Participant driven.
- Cost-effective.
- Prevention focused.
- Performance based.

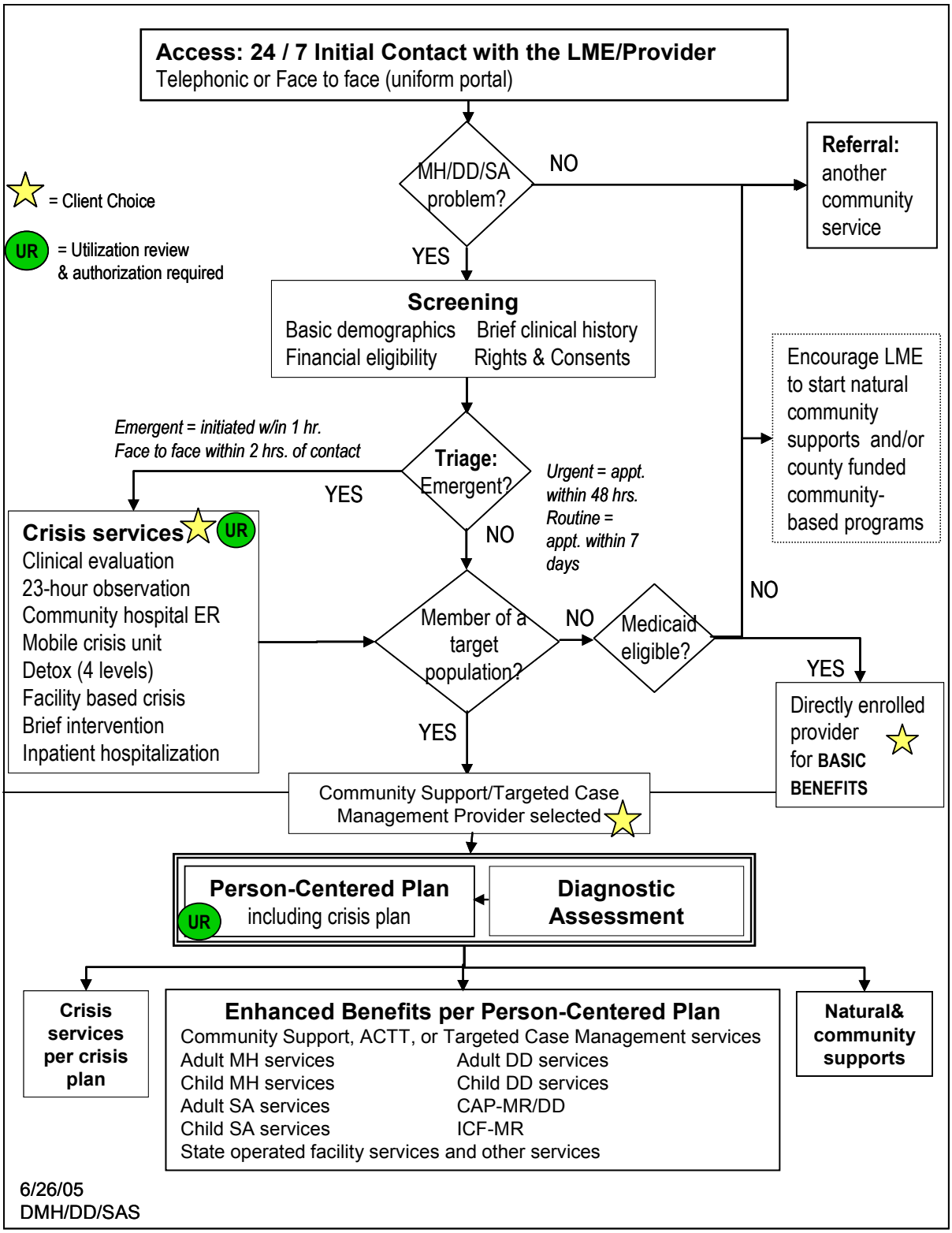
A delivery system must include a pathway for any consumer to follow that will lead to a reduction or stabilization of problems and increase the ability of a consumer to live successfully in the community. The general pathway or flow chart shown in figure 2 is the most likely way to produce the desired outcomes within a reasonable time at justifiable cost.

Local management of the system must be concerned consumer-by-consumer because success for individual consumers is the way to achieve overall system performance. The professional staff that provides the clinical home for the consumer assists in the development and monitors the consumer's person-centered plan. Data is required to determine and communicate the success or failure of implementing that plan as the individualized path for each consumer.

To make the pathway more reliable, the system must have ways to detect "dropouts" or other ways in which the system fails to engage the consumer, so corrective action can be taken to ensure success for each consumer. Together, the providers of services and the local management entity build the success of the system for individual consumers and across all consumers served locally.

To meet the needs of consumers in the most effective means, the legislature directed the State to provide services that are evidence-based or best practices. The assistance of researchers and experts in the fields of mental health, developmental disabilities and substance abuse are essential for the identification and recommendations of such practices to the Division. If selected as a best practice that Division management wants to implement, the Division must obtain approval from the Division of Medical Assistance and the federal Centers for Medicare and Medicaid Services (CMS) to include the practice as part of the enhanced benefit service package.

Figure 4. General Flow Chart for New Consumers



Person-Centered Planning

Person-centered planning is the process of determining the real-life outcomes that are important to individuals and of developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to everyone supported and served in the system. Person-centered planning provides for the individual with the disability to assume an informed and in-command role for life planning and for treatment, service and support options. The individual with a disability and/or the legally responsible person directs the process and shares authority and responsibility with system professionals about the decisions made.[30]

The concept of person-centered planning and comprehensive care is the foundation of all system reform efforts and best practice models for individuals in need of mental health, developmental disabilities, and/or substance abuse services according to the President's New Freedom Commission (see table 1). The national movement has included person-centered planning practices into the design and implementation of individualized services with consumers and their families. Equally so, the Division has established person-centered planning as a fundamental element in the reform of mental health, developmental disabilities and substance abuse service system. There has been much to suggest that a focus on person-centered planning will play an essential role in ensuring the positive experience of recovery and resilience for consumers and family members.[31]

The Division's efforts to design and implement a system of person-centered planning are based on the following principles:

- Person-centered planning builds on the individual's and family's strengths, gifts, skills and contributions.
- Person-centered planning supports consumer empowerment and provides meaningful options for individuals and their families to express preferences and make informed choices in order to identify and achieve their hopes, goals and aspirations.
- Person-centered planning is a framework for providing services, treatment and supports that meet the individual's needs and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
- Person-centered planning supports a fair and equitable distribution of system resources.
- Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging individuals and their families in the community, as they choose.

[30] See the Division's Communication Bulletin #034 entitled "Person-Centered Planning," and Enhanced Services Implementation Updates #1 "CMS Approval of Medicaid State Plan Amendment to Implement the Enhanced Benefit Services Proposed under the Rehabilitation Option (Person-Centered Plans), #8 "Person-Centered Plan", and #11 "Person-Centered Planning Template."

[31] See the Division's Enhanced Services Implementation Update #4 "Transition of Services Authorization, Service Orders, Additional Crosswalks," and #11 "Service Orders."

- Person-centered planning sees individuals in the context of their culture, ethnicity, religion and gender. All the elements that compose a person's individuality are acknowledged and valued in the planning process.
- Person-centered planning supports mutually respectful and partnering relationships between providers/professionals and individuals/families, acknowledging the legitimate contributions of all parties.

In March 2005, the Division announced guidelines for person-centered planning.[32] These guidelines address the underlying values and principles, the essential elements, the required documentation elements and indicators to demonstrate that person-centered planning has occurred.[33] One of the essential elements of the person-centered plan is a crisis plan. Information is to be included concerning proactive steps to prevent crisis from occurring, and processes or procedures to be followed should a crisis event or emergency situation occur.

In April of 2006, person-centered planning became a fundamental part of implementing North Carolina's new service array for people receiving mental health, developmental disabilities and substance abuse services.[34] A standardized format and instructions for developing a person-centered plan (PCP) were distributed for all providers who facilitate plan development for consumers receiving enhanced benefit services. The required standardized format was designed to align with the approved utilization review and authorization processes.

The implementation of this person-centered plan and its components has set the stage for influencing and supporting person-centered thinking and planning for all individuals being served in the system.

Array/Continuum of Services

The continuum of services includes private sector services, community-based public sector services, regionally-based public sector services, and State operated facility services. Ongoing development of local capacity to provide services is a task of the local management entity and, in the long run, will enable the reduced use of state facilities. At the same time, upgrading or replacement of aging state facilities is necessary for those consumers whose needs are beyond the cost-effectiveness at every local level. There are a considerable number of Division publications that address the service array, including communication bulletins and enhanced services implementation updates.[35] Refer to those documents for detailed policy and guidance.

[32] See the Division's Communication Bulletin #034.
[33] See Enhanced Services Implementation Update Memo # 12: Value Options Implementation; and Enhanced Services Implementation Update Memo # 15: Targeted Case Management and Services Authorization through Value Options.
[34] See the Division's Enhanced Services Implementation Update # 8.
[35] See Communication Bulletins and Enhanced Services Implementation Update Memos for additional details on the Division's web site: http://www.dhhs.state.nc.us/mhddsas/announce/index.htm

Services for People with Developmental Disabilities

The services for people with developmental disabilities include an array of habilitation and support services that are available to individuals who qualify for the level of services referred to as Intermediate Care Facilities – Mentally Retarded (referred to as ICF-MR) that are funded by Medicaid. Eligible individuals, who choose community services rather than in an ICF-MR facility, may receive services that are funded by the Community Alternative Program for Developmental Disabilities. This is most often referred to as the CAP-MR/DD waiver. The CAP-MR/DD waiver offers specific services that promote community living and thereby avoid institutionalization. Waiver services compliment and/or supplement services available through the State Medicaid Plan and other State, local and federal programs.[36]

North Carolina's most recent Community Alternative Program for Developmental Disabilities waiver went into effect in September 2005. The specific services that an individual receives under the waiver are based on the person-centered planning process and the identification of the individual's needs. Examples of the types of service that an individual might receive include Day Supports provided in a licensed day setting, Home and Community Supports provided in an individual's home or in the community, Personal Care and Respite. Other services include tangible supports such Augmentative Communication Devices, Home Modifications and Vehicle Adaptations. Individuals who receive waiver funding and live in licensed residential settings such as a group home are supported under the service definition of Residential Supports to meet their habilitation needs in the residential setting.

State funds are also used in these settings to address some support, supervision and care needs. Targeted Case Management is a required service for individuals participating in the waiver. These case managers provide a variety of functions to individuals on the waiver including facilitation of the person-centered planning process and identification of needed waiver services, locating and coordinating those services, as well as monitoring of services to assure services are delivered appropriately to insure the health and safety of the waiver recipient.

For individuals who do not meet the ICF-MR level of care and/or are not CAP-MR/DD waiver recipients, there are a variety of State-funded services. These services are available to individuals who are ineligible for Medicaid and are not CAP recipients, or to individuals who receive Medicaid but are not CAP recipients. Some State-funded services are available to individuals who are CAP recipients to pay for things the waiver

[36] For more about the CAP-MR/DD Waiver, see the Division's Communication Bulletins:
024: CAP/MRDD Waiver Team.
042: Revised Implementation for New CAP-MR/DD Waiver.
045: Approval of CAP-MR/DD Waiver.
And Enhanced Services Implementation Update Memos:
2: CAP-MR/DD Waiver.
13: CAP-MR/DD.
15: CAP-MR/DD and Targeted Case Management.

doesn't cover, such as room and board in a group home. These services include Personal Care, Respite, Supported Employment and Developmental Therapy.

Services for Children and Adolescents with Mental Health or Substance Abuse Needs

The new and revised services that were approved for both Medicaid covered services and for State funding include Community Support services that are often a consumer's clinical home. Interventions that are delivered by Community Support providers include coordination of assessments, the involvement of the child and family team in developing the individual's person-centered plan and the functions of linking the child and his/her family with other needed services or resources. In addition, Community Support providers can provide, for example, training for caregivers, preventive and therapeutic activities that will assist with skill building and development of skills that enable the child and family to have positive relationships with others. Examples of other more intensive services for children and adolescents that were made available in March 2006 are Intensive In-Home Services and Multisystemic Therapy (MST), Day Treatment and Substance Abuse Intensive Outpatient services. Several types of residential treatment continue to be available at varying levels of support and intensity.

The delivery of services for individual children and adolescents is based on person-centered planning by a child and family team.[37] The organizing principle for these services is for communities to have a "system of care." The purpose of a system of care is to make comprehensive, flexible and effective support available for children, youth and families throughout the community and through this assistance make the community a better place to live.

Services for Adults with Substance Abuse Service Needs

The enhanced services implemented in March 2006 include a full continuum of substance abuse services based on the levels of care recognized by the American Society of Addiction Medicine. The service continuum includes Community Support, Mobile Crisis Management, Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Program, Residential Treatment services and Detoxification services. Consumers are able to move from level of care to another base on their level of need and medical necessity. These services are designed to assist individuals with a primary substance abuse disorder to achieve positive life outcomes that support stable and ongoing recovery.

[37] See Enhanced Services Implementation Update Memo # 3: Crosswalk from Old Services to New and Children's Services Issues; Enhanced Services Implementation Update Memo # 5: Developmental Therapy; and Enhanced Services Implementation Update Memo # 11: Children's Residential Treatment Facility Services/EPSDT.

Services for Adults with Serious Mental Illness

As is the case for children and adolescents, the Community Support service is the clinical home for many adults. Other adults may receive more intensive community services such as Assertive Community Treatment Team (ACTT) that comprehensively addresses the needs of adults who have had multiple hospitalizations or other serious functional difficulties related to living successfully in the community. Other adults with mental illness who are on the path to rehabilitation and recovery may need services such as Supported Employment, Psychosocial Rehabilitation Day Services, and/or affordable housing with appropriate levels of support from mental health service providers or other community agencies.[38]

Emergency Services

During State fiscal year 2007, the Division will assist local management entities with the development of a model for a continuum for crisis services for both urban and rural areas with the assistance of a consultant. The model will include:

- 24/7/365 crisis access to services (telephone, walk-in, mobile response, crisis outreach).
- Regional crisis facilities (respite, observation and stabilization units).
- Inpatient facilities (with options for voluntary admission to a psychiatric hospital).
- Transportation.

The development of the continuum will be based upon the findings and recommendations from the Division after conducting an assessment of crisis services and needs throughout the State.[39]

Prevention, education and consultation

House Bill 381 refers to consultation, prevention and education as core services that shall be made available by State and local governments to individuals with mental health, developmental disabilities and substance abuse needs within available resources.
The mission of the Division states it will provide the necessary *prevention*, intervention, treatment, services and supports that individuals need to live successfully in communities of their choice. Prevention programs are reaching a new level of sophistication that includes evidence-based practices, outcome evaluations and cost/benefit considerations. In recent years, developing and delivering prevention services and programs has become a specialty in its own right.

[38] See the Division's Communication Bulletin #007 "Best Practice-Adult Mental Health."
[39] See the Division's Communication Bulletin #035 entitled "Policy Guidance (Provision of Local Crisis Services), Communication Bulletin #048 "Service Transition Guidance: How to Use Existing Definitions in Transition-Mobile Crisis Management" and Communication Bulletin #061 "Partners for Planning Regional Crisis Services."

Prevention implies taking advance measures against something possible or probable. Within the Division, prevention may be designed to inform and teach individuals, various groups or the population at large about the insights and skills related to healthy living. Prevention may also support policies that prevent undesired consequences, such as death or injury due to driving while intoxicated. Local business plans must address how prevention will be provided in the catchment area.

Education is defined as a practice of developing mentally, morally or aesthetically, especially by instruction or to provide with information. Within the Division, education is designed to inform and teach various groups including persons being served, families, schools, businesses, churches, industries, civic and other community groups about the nature of mental illness, developmental disabilities and substance abuse and the services and supports in the state and community. Local business plans must outline how education will be provided.

Consultation is defined as professional advice or services. Within the Division, these services are provided to other agencies, groups, or organizations and to individual practitioners to promote planning and development of services. Training and technical assistance may be offered directly, or by a contracted consultant, regarding the development of practices, tools, and resources. Local management entities may provide consultation to their providers in an effort to maintain continuity. Local business plans must outline how they will provide this service to the community.

Past methods of prevention within the Division and its contract providers have mainly focused on substance abuse prevention, working with the federal Center for Substance Abuse Prevention (CSAP) and other nationally known prevention agencies. New prevention and intervention methods are crossing disability categories.

The Division is currently developing and creating a comprehensive prevention plan that will be culturally competent, utilize evidence-based techniques and involve best practice. This plan will guide the Division, local management entities, providers, consumers, advocates and other stakeholders to engage in prevention and early intervention practices throughout the State.

State Operated Facilities

The Department of Health and Human Services has committed to the construction of a new regional psychiatric hospital in Butner, North Carolina. The 432 bed facility will serve persons who need inpatient psychiatric services in both the north and south central regions of the state. Dorothea Dix Hospital in Raleigh and John Umstead Hospital in Butner continue to provide services until remaining patients and admissions can be accommodated in the new facility. Construction is expected to be completed by late summer of 2007. The General Assembly has also approved construction of new facilities to replace Cherry and Broughton Hospitals within the next eight years.

Between State fiscal year 2002 and State fiscal year 2005 the psychiatric hospitals engaged in efforts to downsize. Target reductions were met for skilled nursing and adult long-term units. The number of gero-psychiatric beds was also reduced, although current census exceeds the target capacity. Due to increased admissions and census, no adult admission units have been downsized. Downsizing the hospitals continues to be a goal and the Division is developing a new plan to address further downsizing of the admissions units.

The Division is transforming the alcohol and drug abuse treatment centers (ADATCs) to increase acute capacity in order to serve individuals with substance abuse disorders who are involuntarily committed. This increased capacity will divert involuntary substance abuse commitments from the state psychiatric hospitals and provide immediate access for individuals needing inpatient substance abuse treatment interventions. Strategic planning is ongoing with the ADATCs to operationalize their new mission to provide medically monitored detoxification, crisis stabilization and short-term treatment to prepare adults with substance abuse problems for ongoing community-based recovery services. The ADATCs are in the process of implementing a redesigned evidence based treatment model for individuals who require inpatient treatment in order to initiate recovery before returning to ongoing treatment in the community.

The Division continues its efforts to downsize the developmental centers by working closely with consumers who are interested in receiving community services, their guardians, local management entities and providers. Specialized programs have been established at the developmental centers to provide time-limited active treatment for individuals meeting specific admission criteria and who have been unsuccessful in the community. The specialized services at the developmental centers have either not been available in the individuals' home communities or have not been sufficient to meet intensive, complex needs. The goal of the specialized programs is to provide individualized, multi-disciplinary services, while working in partnership with local management entities to prepare individuals for successful transition back to their communities.

Practice Improvement Collaborative

While a first foundation of services has been approved by the federal Centers for Medicare and Medicaid Services and was implemented in March 2006, the ongoing North Carolina Practice Improvement Collaborative (PIC) continues to monitor research and development of promising best practices for possible adoption by North Carolina.

The mission for the Practice Improvement Collaborative is to ensure that each time any North Carolinian comes into contact with the mental health, developmental disabilities and substance abuse services system he or she will receive excellent care that is consistent with the scientific understanding of what works.

Comprised of representatives specializing in all three disabilities, the Practice Improvement Collaborative meets quarterly to review and discuss relevant programs. Annually, the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum, defined as the North Carolina Practice Improvement Congress, will feature brief educational descriptions of the practices being recommended by the Practice Improvement Collaborative in its report.

Workforce Development

Early in the process of system reform, the Division recognized that development of the workforce would be a significant and complex issue to ensure the success of transformation. This issue involves professional standards, the requirements of service definitions, determination and measurement of competencies, availability of curricula and educational opportunities, and the development and implementation of strategies to build a statewide workforce. The Division recognizes that workforce development for the system is part of a much greater situation for the entire State. The Division is participating in the Department's initiative to address workforce issues in all of human services.[40]

In 2001, the Division identified some specific strategies, such as the establishment of regional training facilities that were later eliminated due to the lack of sufficient Division infrastructure to operate. The 2001 tasks that focused on the reasonable compensation of the workforce have also been deleted because these are beyond the scope of the Department. While the State establishes rates paid for services and requires certain types and levels of training as a compliance measure, market forces actually control the rates paid by private providers to staff.

During 2002-2003, initial training was begun along with technical assistance to local management entities in collaboration with the North Carolina Council for Community Programs. Workshops were held on person-centered planning and the new service definitions. In depth training has evolved and is ongoing. The North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services in conjunction with the Division has undertaken workforce development as a priority initiative for State fiscal year 2007.

[40] See Communication Bulletin # 22: Workforce Development Plan (Final); Communication Bulletin # 33: Clinical Skills Series (Faculty Application); Enhanced Services Implementation Update Memo # 1: CMS approval of Medicaid State Plan Amendment (SPA) to implement the Enhanced Benefit Services proposed under the Rehabilitation Option. (Training); and Enhanced Services Implementation Update Memo # 10: Courses which Satisfy the Training Requirements for Service Definitions; and Communication Bulletin # 51: (DRAFT) Cultural and Linguistic Competency Action Plan.

Appendices

A. Applicable provisions from legislation.
B. Glossary.
C. Index to State Plans 2001 through 2005 by topic.
D. Detailed tasks and status of tasks from prior State Plans.

Appendix A. Applicable Provisions from Legislation

The following excerpts from Session Law 2001-437, HB 381 specify significant provisions for reform of the mental health, developmental disabilities and substance abuse services system.

Part 1.

"Section 1.1 State and local government to provide mental health, developmental disabilities and substance abuse services through **a delivery system** designed to meet the needs of clients in the **least restrictive**, **therapeutically most appropriate setting available** and to **maximize their quality of life**. It is further the obligation of the State and local government to provide **community-based services** when such services are appropriate, unopposed by the affected individuals, and can be reasonably accommodated within **available resources** and taking into account the needs of others persons for mental health, developmental disabilities, and substance abuse services.

State and local governments shall develop and maintain a **unified system of services** centered in **area authorities or county programs**. The public service system will strive to provide a **continuum of services** for clients while considering the availability of services in the private sector. Within **available resources**, State and local government shall ensure that the following **core services** are available:

(1) Screening, assessment, and referral.
(2) Emergency Services.
(3) Service coordination.
(4) Consultation, prevention, and education.

Within **available resources**, the State shall provide funding to support services to **targeted populations** [those individuals given service priority under the State Plan], except that the State and counties shall provide **matching funds** for entitlement program services as required by law.

As used in this Chapter, the phrase '**within available resources'** means State funds appropriated and non-State funds and other resources appropriated, allocated or otherwise made available for mental health, developmental disabilities and substance abuse services.

The furnishing of services to implement the policy of this section requires the cooperation and financial assistance of counties, the State, and the federal government."

Section 1.3. states:

Human rights committees responsible for protection the **rights of clients** shall be established at each **State facility** and for each **area authority and county program**. The Commission shall adopt **rules** for the establishment, composition, and duties of the committees and procedures for appointment and coordination with the **State and Local Consumer Advocacy programs**.

Section 1.4 states:

Within the public system of MH/DD/SA services, there are area, county and State facilities. An **area authority or county program is the locus of coordination** among public services for clients of its catchment area.

Section 1.5, states:

The Department shall develop and implement a State Plan that includes:

1. **Vision and mission**.
2. **Organizational structure** of the Department and the divisions of the Department responsible for managing and monitoring MH/DD/SA services.
3. **Protection of client rights and consumer involvement** in planning and management of system services.
4. Provision of services to **targeted populations**, including criteria for identifying targeted populations.
5. **Compliance with federal mandates.**
6. **Core services that are available to all individuals**.
7. **Service standards**.
8. **Uniform portal** process.
9. **Strategies and schedules for implementing** the service plan, including **consultation on Medicaid policy**, **intersystem collaboration**, promotion of **best practices**, **technical assistance**, **outcome-based monitoring**, and **evaluation**.
10. A **plan for coordination** with the Medicaid State Plan, and NC Health Choice.
11. A **business plan** to demonstrate efficient and effective resource management, including strategies for accountability for non-Medicaid and Medicaid services.
12. Strategies and schedules for implementing a phased in **plan to eliminate disparities in the allocation of State funding** across county programs and area authorities by January 1, 2007, including **methods to identify service gaps** and to ensure equitable use of State funds to fill those gaps among all counties."

Section 1.6 states:

The **Secretary** shall administer and enforce the provisions of this Chapter and the **rules** of the Commission and shall operate **State facilities**. An **area director or program director** shall administer **the programs** of the area authority or county program, as applicable, and **enforce the rules** of the area board, applicable State laws, rules of the Commission, and rules of the Secretary. The Secretary in cooperation with area and county program directors and State facility directors shall provide for the **coordination of public services between area authorities, county programs, and State facilities."**

Section 1.7 states that the Secretary shall do all of the following:

(1) Oversee development of the **State Plan**.

(2) Enforce the **provisions** of this Chapter and the **rules** of the Commission and the Secretary.

(3) Establish a process and criteria for the submission, review, and approval or disapproval of **business plans submitted by area authorities and counties**.
(4) **Adopt rules** specifying the content and format of business plans.
(5) Review business plans and, upon approval of the business plan, **certify the submitting area authority or county program** to provide services.
(6) Establish comprehensive, cohesive **oversight and monitoring procedures** and processes to ensure continuous compliance by area authorities, county programs, and all providers of public services with State and federal policy, law, and standards. Procedures shall include **performance measures** and **report cards** for each area authority and county program.
(7) **Conduct regularly scheduled monitoring and oversight** of area authority, county programs, and all providers of public services. Monitoring and oversight shall include compliance with the program business plan, core administrative functions, and fiscal and administrative practices and shall also address outcome measures, consumer satisfaction, client rights complaints, and adherence to best practices.
(8) Make findings and **recommendations** based on (7) to the applicable area authority board, county program director, board of county commissioners, providers of public services, and to the Local Consumer Advocacy Office.
(9) **Assist** area authorities and county programs in the **establishment and operation of community-based programs.**
(10) **Operate State facilities** and adopt **rules** pertaining to their operation.
(11) Develop a **unified system of services** provided in area, county, and State facilities, and by providers enrolled or under a contract with the State.
(12) Adopt **rules** governing the **expenditure of all funds** for mental health, developmental disabilities, and substance abuse programs and services.
(13) Adopt **rules** to implement the **appeal procedure** authorized by G.S. 122C-151.2.
(14) Adopt **rules** for the implementation of the **uniform portal** process.
(15) Except as provided in G.S. 122C-26(4), adopt **rules** establishing procedures for **waiver of rules** adopted by the Secretary under this Chapter.
(16) Notify the clerks of superior court of changes in the designation of **State facility regions** and of facilities designated under G.S. 122C-252.
(17) **Promote public awareness and understanding** of mental health, mental illness, developmental disabilities, and substance abuse.
(18) Administer and enforce **rules** that are conditions of participation for federal or State financial aid.
(19) Carry out G.S. 122C-361.
(20) **Monitor the fiscal and administrative practices** of area authorities and county programs to ensure that the programs are accountable to the State for the management and use of federal and State funds allocated for mental health, developmental disabilities, and substance abuse services. The Secretary shall **ensure maximum accountability** by area authorities and county programs for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further ensure that the practices are consistent with professionally accepted accounting and management principles.

(21) Provide **technical assistance**, including conflict resolution, to counties in the development and implementation of area authority and county program business plans and other matters, as requested by the county.
(22) Develop a **methodology** to be used for calculating **county resources** to reflect cash and in-kind contributions of the county.
(23) Adopt **rules** establishing **program evaluation and management** of mental health, developmental disabilities, and substance abuse services.
(24) Adopt **rules** regarding the requirements of the federal government for grants-in-aid.
(25) Adopt **rules** for determining **minimally adequate services** for purposes of G.S. 122C-124.1 and G.S. 122C-125.
(26) Establish a **process for approving area authorities and county programs to provide services** directly in accordance with G.S. 122C-141.
(27) **Sponsor training** opportunities in the fields of mental health, developmental disabilities, and substance abuse.
(28) **Enforce the protection of the rights of clients** served by State facilities, area authorities, county programs, and providers of public services.
(29) Adopt **rules** for the enforcement of the protection of the rights of clients being served by State facilities, area authorities, county programs, and providers of public services.
(30) Prior to **requesting approval to close a State facility** under G.S. 122C-181(b):
a. Notify the Joint Legislative Commission on Governmental Operations, the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and members of the General Assembly who represent catchment areas affected by the closure; and
b. Present a plan for the closure to the members of the Joint Legislative Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Health and Human Services for their review, advice, and recommendations. The plan shall address specifically how patients will be cared for after closure, how support services to community-based agencies and outreach services will be continued, and the impact on remaining State facilities. In implementing the plan, the Secretary shall take into consideration the comments and recommendations of the committees to which the plan is presented under this subdivision.
(31) Ensure that the **State Plan** for Mental Health, Developmental Disabilities, and Substance Abuse Services is coordinated with the Medicaid State Plan and NC Health Choice.
(b) The Secretary may do the following:
(1) Acquire, by purchase or otherwise in the name of the Department, **equipment, supplies, and other personal property** necessary to carry out the mental health, developmental disabilities, and substance abuse programs.
(2) Promote and conduct **research** in the fields of mental health, developmental disabilities, and substance abuse; promote best practices.
(3) **Receive donations** of money, securities, equipment, supplies, or any other personal property of any kind or description that shall be used by the Secretary for the purpose of carrying out mental health, developmental disabilities, and substance abuse

programs. Any donations shall be reported to the Office of State Budget and Management as determined by that office.

(4) Accept, allocate, and spend any **federal funds** for mental health, developmental disabilities, and substance abuse activities that may be made available to the State by the federal government. This Chapter shall be liberally construed in order that the State and its citizens may benefit fully from these funds. Any federal funds received shall be deposited with the Department of State Treasurer and shall be appropriated by the General Assembly for the mental health, developmental disabilities, or substance abuse purposes specified.

(5) Enter into **agreements** authorized by G.S. 122C-346.

(6) Notwithstanding G.S. 126-18, authorize **funds for contracting** with a person, firm, or corporation for aid or assistance in locating, recruiting, or arranging employment of health care professionals in any facility listed in G.S. 122C-181.

(7) **Contract with one or more private providers or other public service agencies** to serve clients of an area authority or county program and **reallocate program funds** to pay for services under the contract if the Secretary finds all of the following:

a. The area authority or county program refuses or has failed to provide the services to clients within its catchment area, or provide specialty services in another catchment area, in a manner that is at least adequate.

b. Clients within the area authority or county program catchment area will either not be served or will suffer an unreasonable hardship if required to obtain the services from another area authority or county program.

c. There is at least one private provider or public service agency within the area authority or county program catchment area, or within reasonable proximity to the catchment area, willing and able to provide services under contract.

Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area authority or county program and to the applicable participating boards of county commissioners of the Secretary's intent to contract and shall provide the area authority or county program and the applicable participating boards of county commissioners an opportunity to be heard.

(8) **Contract with one or more private providers or other public service agencies** to serve clients from more than one area authority or county program and reallocate the funds of the applicable programs to pay for services under the contract if the Secretary finds either that there is no other area authority or county program available to act as the administrative entity under contract with the provider or that the area authority or county program refuses or has failed to properly manage and administer the contract with the contract provider, and clients will either not be served or will suffer unreasonable hardship if services are not provided under the contract. Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area authority or county program and the applicable participating boards of county commissioners of the Secretary's intent to contract and shall provide the area authority or county program and the applicable participating boards of county commissioners an opportunity to be heard.

(9) **Require reports of client characteristics, staffing patterns, agency policies or activities, services, or specific financial data** of the area authority, county program, and providers of public services. The reports shall not identify individual clients of the area

authority or county program unless specifically required by State law or by federal law or regulation or unless valid consent for the release has been given by the client or legally responsible person."

Section 1.8 addresses the duties of counties.
Section 1.9 addresses county governance and operation of services, local business plans, dissolution of area authorities/county programs.
Section 1.10 addresses the powers and duties of an area authority.
Section 1.11 addresses the area board.
Section 1.12 addresses the area director.
Section 1.13 addresses corrective action by the Secretary.
Section 1.14 repealed.
Section 1.15 addresses the duties of the area authority for contracting for the provision of services.
Section 1.16-1.17 addresses disputes and appeals by area authorities.
Section 1.18 addresses personnel.
Section 1.19 addresses state facilities.
Section 1.20 addresses early intervention.
Section 1.21 addresses the Commission for MH/DD/SAS.

Part 2 of HB 381 addresses the Consumer Advocacy Program.

Appendix B. Glossary

ACCESS – An array of treatments, services and supports is available; consumers know how and where to obtain them; and there are no system barriers or obstacles to getting what they need, when they are needed.
ACCREDITATION – Certification by an external entity that an organization has met a set of standards.
ACUITY – (or acuity level) Used, most often in hospital settings, to describe the intensity of a person's needs for care.
ACUTE ABSTINENCE SYNDROME - A group of withdrawal signs and symptoms that occur shortly after a person who is physically dependent on a drug stops taking it.
AVERAGE DAILY CENSUS (ADC) – Measurement of the number of people residing in a residential program, usually hospitals.
ADULT CARE HOME – An assisted living residence in which 24-hour scheduled and unscheduled personal care services are provided to two or more residents. Some licensed adult care homes provide supervision to people with cognitive impairments who need supervision because their decisions, if made independently, may jeopardize their own or others' safety or well being. Designated, trained staff home may administer medications. Adult care homes that provide care for two to six unrelated residents are commonly called family care homes.
ADVANCE DIRECTIVE - A legal document that allows consumers to plan their own mental health care in the event the individual loses the capacity to effectively make decisions. The individual can name a friend and/or an agent (friend or family) to act on his/her behalf to give guidance to the professionals involved in care, treatment according to his/her preferences. Completing an advance directive is an opportunity for the person with disabilities to learn more about the illness and have more control what happens.
ADVOCACY – Activities in support of, or on behalf of, people with mental illness, developmental disabilities or addiction disorders including protection of rights, legal and other service assistance, and system or policy changes. On example of advocacy and consumer empowerment is participation in state or local CFACs.
AFTERCARE- Supervision or treatment given individuals for a limited time after they are released from a treatment program.
ALCOHOL, TOBACCO, AND OTHER DRUGS (AOD) – Substance abuse treatment.
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) - An international organization of physicians dedicated to improving the treatment of people with substance use disorders by educating physicians and medical students, promoting research and prevention, and informing the medical community and the public about issues related to substance use. In 1991, ASAM published a set of patient placement criteria that have been widely used and analyzed in the alcohol, tobacco and other drug (ATOD) field.
APPEALS PANEL - The state mh/dd/sa appeals panel established under NC. G.S. 371 and G.S. 122C-151.4
AREA AUTHORITY means the area mental health, developmental disabilities, and substance abuse authority.
AREA BOARD means the area mental health, developmental disabilities, and substance abuse board.

AREA DIRECTOR – The executive who is responsible for mental health, developmental disability, and substance abuse services in a county/area program. This person has at least a master's degree in a behavioral health services discipline and is responsible for developing a system of care in his/her local area that brings all possible public and private services into a network. The network must meet the needs of service consumers in that region and conform to the requirements of the DMH/DD/SAS.
AREA AUTHORITY/COUNTY PROGRAM – A program that is certified by the DHHS Secretary to manage, oversee and sometimes directly provide mental health, developmental disabilities and substance abuse services in a specified geographic area. Most area programs have already changed or will soon be changing to Local Management Entities.
ARRAY OF SERVICES - Group of services available to a consumer.
ASSERTIVE COMMUNITY TREATMENT (ACT) – A research-based, multi-disciplinary team providing community-based treatment, rehabilitation and support services to consumers who are at risk of frequent decompensation and hospitalization, arrest or homelessness. ACT Teams maintain primary clinical responsibility and provide services 24 hours a day, seven days a week on a long-term basis. This allows for continuity of caregivers, and thus for increased stability in community living.
ASSESSMENT – A comprehensive examination and evaluation of a person's needs for psychiatric, developmental disability or substance abuse treatment, services and/or supports according to applicable requirements.
AUTONOMY – An ethical principle that requires policy-makers, advocates, planners, administrators, providers and family members of adult service consumers to respect the right of legally competent individuals to make decisions about the course of their lives.
BASIC BENEFITS – Mental health, developmental disability or substance abuse services that are available to North Carolina residents who need them.
BED DAY ALLOCATION – A system in which the DMH/DD/SAS sets the number of state psychiatric hospital beds or mental retardation center admissions county/area programs may "buy" in a particular time period. These allocations take into account past usage and private beds available in each geographic area.
BENCHMARK - An established standard of achievement used as a point of reference to assess performance.
BEST PRACTICE (S) – Interventions, treatments, services or actions that have been shown to generate the best outcomes or results. The terms, evidence-based, or research-based may also be used.
BIOPSYCHOSOCIAL – Medical (biological), psychological, and social or environmental influences on a person's behavior and/or condition.
BLOCK GRANT – Funds received from the federal government (or others), in a lump sum, for services specified in an application plan that meet the intent of the block grant purpose. See also, CATEGORICAL FUNDING.
BOARD OF COUNTY COMMISSIONERS includes the participating boards of county commissioners for multi-county area authorities and multi-county programs.
CAP/MR-DD WAIVER – A Medicaid community care funding source for persons with MR/DD who require an ICF/MR level of care that offers specific services in the community.

CASE MANAGEMENT –The activities of a professional with a great deal of knowledge of the services and programs supported by the public mh/dd/sa system who advocates for access and links individuals to the services. Case managers may be publicly or privately provided.
CATCHMENT AREA - The geographic part of the state served by a specific area or county program.
CATEGORICAL FUNDING – Funds provided for specific purposes or for services to specific people.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) - The federal agency responsible for overseeing the Medicare and Medicaid programs.
THE CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP) - A federal organization that provides national leadership in development of policies, programs, and services to prevent the onset of illegal drug use, to prevent underage alcohol and tobacco use, and to reduce the negative consequences of using substances. CSAP is one of three Centers in the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS).
THE CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT) - of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was created in October 1992 with a congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT's initiatives and programs are based on research findings and the general consensus of experts in the addiction field that, for most individuals, treatment and recovery work best in a community-based, coordinated system of comprehensive services. Because no single treatment approach is effective for all persons, CSAT supports the nation's effort to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches.
CERTIFICATION – A statement of approval granted by a certifying agency confirming that the program/service/agency has met the standards set by the certifying agency. CMS is an example of a certifying agency. See also ACCREDITATION.
CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE (CAFAS) – Measurement system to determine the level of functioning of a child or adolescent.
CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM (CA LOCUS) –System used to determine the appropriate level or intensity of services/supports for children and adolescents.
CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT (CRIPA) - Federal law intended to assure that persons involuntarily detained in state psychiatric hospitals or mental retardation centers are treated safely, humanely and with adequate due process as required under the U.S. Constitution. CRIPA investigations are undertaken and litigated by the Department of Justice, Civil Rights Division.
CLAIM – An itemized statement of services, performed by a provider network member or facility, which is submitted for payment.
CLIENT - An individual who is admitted to or receiving public services. "Client" includes the client's personal representative or designee. See also CONSUMER.
CLIENT ADVOCATE means a person whose role is to monitor the protection of client rights or to act as an individual advocate on behalf of a particular client in a facility.

CLINICAL SERVICES - In mh/dd/sa services, this usually means activities of medical and related professionals. These professionals generally include psychiatrists, social workers, psychologists, nurses and counselors.
CLINICAL BEST PRACTICE – Consumer-focused, evidenced-based interventions and/or clinical services that demonstrate the best outcomes for consumers.
CLINICAL SUPERVISION - Intermittent face–to–face contact between a clinical supervisor and treatment staff to ensure that each person being served has an individualized treatment plan and is receiving quality care. It also includes auditing patient files, review and discussion of active cases and direct observation of treatment. In substance abuse treatment, it also means applying supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility, problem identification and resolution, referral for screening, specialized education, alternative activities development, social policy development, environmental change, training and development of risk reduction skills.
COMMISSION means the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, established under Part 4 of Article 3 of Chapter 143B of the General Statutes.
COMPETENCE – The capacity to function effectively. Also a legal term (i.e. competency to stand trial or competency to make decisions in one's own best interest). An individual must be judged incompetent in a court of law or found dangerous to self or others before the person's civil rights may be restricted.
COMPLAINT – An expression of concern in writing or orally regarding rights, services or administrative issues that the complainant perceives as a problem.
CONFIDENTIAL INFORMATION means any information, whether recorded or not, relating to an individual served by a facility that was received in connection with the performance of any function of the facility. "Confidential information" does not include statistical information from reports and records or information regarding treatment or services which are shared for training, treatment, habilitation, or monitoring purposes that does not identify clients either directly or by reference to publicly known or available information.
CONSULTATION – Information shared between or among peers or professionals to increase the ability to manage challenging circumstances. Psychiatric consultation to a cardiologist who is treating a depressed patient is an example. A social worker might consult with another on the best residential placement for an individual with severe and persistent mental illness.
CONSUMER – An individual who has been or is receiving publicly funded mental health, developmental disability or substance abuse services or supports. See also CLIENT.
CONSUMER AND FAMILY ADVISORY COMMITTEE (CFAC) – A committee of ordinary people who get help from the area program or whose loved ones do. It is their job to advise the area program how to design the reformed system.
CONSUMER OUTCOMES - The extent to which individuals receiving services and supports designed to assist in this process reach their life goals. For example, an adult

consumer is competitively employed or a child with severe emotional disturbance who attends school regularly.
CO-OCCURRING DISORDERS – The presence of two or more disorders at the same time (e.g. substance abuse and mental illness; developmental disability and mental illness; substance abuse and physical health conditions). See also, DUAL DIAGNOSIS.
CORE SERVICES – Services such as screening, assessment, crisis or emergency services available to any person who needs them. Also, universal services such as education, consultation and prevention activities intended to increase knowledge about mental illness, addiction disorders, or developmental disabilities, reduce stigma associated with them and/or prevent avoidable disorders.
CRISIS – Response to stressful life events that may seriously interfere with a person's ability to manage. A crisis may be emotional, physical, or situational in nature. The crisis is the perception of and response to the situation, not the situation itself.
CRISIS INTERVENTION - Services and supports aimed at helping a person manage a crisis safely and return to his or her regular life.
CRISIS RESPONSE – Immediate response to assess for acute mh/dd/sa service needs, to assist with acute symptom reduction, and to ensure that the person in crisis safely transitions to appropriate crisis stabilization services. These services are available 24 hours per day, 365 days per year.
CRISIS STABILIZATION – Services and supports following crisis response that are intended to assist the person in crisis to return to his/her regular life.
CULTURAL – A group of learned behaviors that a certain group of people have in common. They include thoughts, communications, actions, customs, beliefs, values and institutions of different racial, ethnic, religious, age or social groups.
CULTURAL COMPETENCE –A process that promotes development of skills, beliefs, attitudes, habits, behaviors and policies which enable individuals and groups to interact appropriately, showing acceptance and understanding of others.
DE-INSTITUTIONALIZATION – Release of people, especially mental health patients, from institutions to care, treatment and supports in communities. , De-institutionalization became national policy with the Community Mental Health Centers Act of 1963. The 1997 Supreme Court decision in OLMSTEAD V. LC has given new momentum to development of community based services for individuals who have remained in state hospitals and mental retardation centers because community services were not available.
DEPARTMENT means the North Carolina Department of Health and Human Services.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, (DHHS) – North Carolina agency that oversees state government human services programs and activities.
DETOXIFICATION - A medically supervised treatment program for alcohol or other drug addiction designed to purge the body of intoxicating or addictive substances. It is often used as a first step in overcoming physical or psychological addiction.
DEVELOPMENTAL DISABILITY - A severe, chronic disability of a person which: a) is attributable to a mental or physical impairment or combination of mental and physical impairments; b) is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22; c) is likely to continue indefinitely and, d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic

self-sufficiency; and e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or f. when applied to children from birth through four years of age, may be evidenced as a developmental delay. GS131D-2

DIAGNOSTIC AND STATISTICAL MANUAL (DSM IV) – A book, published by the American Psychiatric Association, of special codes that identify and describe mh/dd/sa disorders.

DIMENSION - A term used in the ASAM (American Society of Addiction Medicine) patient placement criteria referring to one of six patient problem areas that must be assessed when making placement decisions.

DIVERSION –Choosing lower cost and/or less restrictive services and/or supports. For example, choosing a community program instead of sending a person to a state hospital. The term is also used when preventing arrest or imprisonment by placing the individual in treatment. See also, UTILIZATION REVIEW and PRE-AUTHORIZATION.

DIVERSION PROGRAMS - Programs designed to screen people out of the criminal justice system and into appropriate treatment services before they are imprisoned. In North Carolina diversion programs are in place in response to SB859 which prohibits admission of persons with mental retardation to public psychiatric hospitals.

DIVISION means the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (DMH/DD/SAS) - A division of the State of North Carolina, Department of Health and Human Services responsible for administering and overseeing public mental health, developmental disabilities and substance abuse programs and services.

DOMAINS - major areas of concern to the NC public mh/dd/sa system and its mission, goals, and strategies and for which indicators and measures are developed. Examples include access to services and quality of care. The term may also refer to major areas of functioning in life, such as personal relationships, work, school and living arrangements.

DUAL DIAGNOSIS – Having more than one disorder or condition such as physical illness and mental illness, mental illness or developmental disability and substance abuse. Since the word dual implies two and it is possible for an individual to have many conditions or disorders, CO-OCCURRING DISORDERS is the more accurate term.

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT) – Services provided under Medicaid to children under age 21 to determine the need for mental health, developmental disabilities or substance abuse services. Providers are required to provide needed service identified through screening.

EDUCATION – Activities designed to increase awareness or knowledge about any and all aspects of mental health, mental illness, developmental disability or substance abuse to individuals and/or groups. See also, PREVENTION. Also, activities or programs designed to ensure that service providers are competent to provide services; identified as best practices.

EMERGENCY SERVICES – Services designed to assist individuals in an acute crisis that are, or are likely to become, dangerous to themselves or others. Emergency Rooms of general hospitals are one example. See also, CRISIS SERVICES.

EMERGING PRACTICES - Treatments and services that are promising but less thoroughly documented as defined by the President's New Freedom Commission on Mental Health

EVIDENCE BASED PRACTICES - as defined by the Institute of Medicine (IOM), is the integration of best research evidence with clinical expertise and patient values.

FAMILY SUPPORT – Persons identified by the consumer as either family members or significant others who provide the necessary support for furthering quality of life, attainment of personal life goals or recovery.

FEDERAL CONFIDENTIALITY LAW GOVERNING ALCOHOL AND DRUG ABUSE PATIENT RECORDS, 42 CFR, part 2 - A federal statute regulating the release of alcohol and drug abuse patient records and patient identifying information.

FIDELITY SCALES - Fidelity refers to the degree of implementation of an evidence-based practice (EBP). A fidelity scale measures fidelity. Such scales have been developed for each of the six EBPs included in the Implementing EBP Project (assertive community treatment, supported employment, integrated treatment for dual disorders, illness management, family psychoeducation, and medication guidelines).

FOLLOW-UP - Checking on the progress of a person who has completed treatment or other services, has been discharged or has been referred to other services and supports.

GEOGRAPHIC ACCESSIBILITY – A measure of access to services, generally determined by drive/travel time or number and type of providers in a service area.

HABILITATION – Activities, treatments, services and/or supports that assist the individual to effectively accomplish activities of daily living.

HEALTH CHOICE – The health insurance program for children in North Carolina that provides comprehensive health insurance coverage to uninsured low-income children. Financing comes from a mix of federal, state, and other non-appropriated funds.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – A federal Act that protects people who change jobs, are self-employed, or who have pre-existing conditions. The Act aims to make sure that prospective or current service consumers are not discriminated against based on health status.

HOME AND COMMUNITY BASED SERVICES (HCBS)- Refers to a federal waiver of Medicaid requirements permitted under the Social Security Act that permits payment for services not ordinarily covered by the Medicaid state plan or to be delivered in a different amount, duration, and scope than services offered by the Medicaid state plan. Federal regulations under the waiver may target specific groups of individuals, such as persons with developmental disabilities, traumatic brain injury, or chronic mental illness, or target specific geographic areas of a state. It also permits the state to set different financial eligibility limits so that additional persons may become eligible for Medicaid through the waiver.

INPATIENT – A person who is hospitalized.

INTERMEDIATE CARE FACILITY (ICF) - An institution licensed under state law to provide health related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility (SNF) provides.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES (ICFMR/DD) – A facility that provides ICF level of care to eligible persons who have mental retardation or developmental disabilities.

INDICATORS - Measurable evidence of the results of activities related to a particular area of concern. Examples include the percent of adult consumers employed or the percent of children with serious emotional disturbance attending school regularly.
INTEGRATED PAYMENT AND REPORTING SYSTEM (IPRS) - An electronic, web-based system for reporting services and making payments that will eventually replace the Willie M., Thomas S., and Pioneer systems of claims processing. The IPRS system will be built on the existing Medicaid Management Information System (MMIS) currently processing Medicaid claims for the Division of Medical Assistance, (DMA). The goal of the IPRS project is to replace the existing UCR systems with one integrated system for processing and reporting all MH/DD/SAS and Medicaid claims.
INTENSITY OF NEED – A measurement of the amount, duration, scope, frequency and cost of a benefit package for a specific individual.
INTENSITY OF SERVICE - The degree or extent to which a treatment or service is provided, depending on a patient' level of need. Some treatments and services are considered more intensive than others. For example, medically managed inpatient treatment is more intensive than outpatient treatment, or a halfway house. Other services, such as vocational training, can be more or less intense, depending on patient needs.
INTERVENTION - Activities aimed at interrupting an action or a behavior that is harmful to progress and recovery.
JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) – Agency that reviews the care provided by hospitals and determines whether accreditation is warranted.
LEVEL OF CARE (LOC)- A structured system of types of care. For substance abuse programs, as used in the ASAM criteria for substance abuse, this term refers to four broad areas of treatment placement, ranging from inpatient to outpatient.
LICENSURE – A state or federal regulatory system for service providers to protect the public health and welfare. Licensure of healthcare professionals and hospitals are examples.
LOCAL BUSINESS PLAN – A comprehensive plan required of local management entities for mental health, developmental disabilities and substance abuse services in a certain geographical area.
LOCAL FUNDS means fees from services, including client payments, Medicare and the local and federal share of Medicaid receipts, fees from agencies under contract, gifts and donations, and county and municipal funds, and any other funds not administered by the Division.
LOCAL MANAGEMENT ENTITY (LME) - The local agency that plans, develops, implements and monitors services within a specified geographic area according to requirements of the DMH/DD/SAS. Includes developing a full range of services that provides inpatient and outpatient treatment, services and/or supports for both insured and uninsured individuals. See also area/county program.
MEASURES - Methodologies applied to derive and calculate indicators of performance.
MEDICAID – A jointly funded federal and state program that provides hospital and medical expense coverage to low-income individuals and certain elderly people and people with disabilities.
MEDICAL NECESSITY - Criteria established to ensure that treatment is necessary and appropriate for the condition or disorder for which the treatment is provided. Review

methods include retrospective, concurrent and pre-treatment reviews. See UTILIZATION REVIEW.
MEDICARE – A federal government hospital and medical expense insurance plan primarily for elderly people and people with disabilities.
MEDICARE PART A – The part of Medicare that provides basic hospital coverage automatically for most eligible persons over sixty-five or for people with disabilities.
MEDICARE PART B – A voluntary program that is part of Medicare and provides benefits to cover the costs of physician services.
MEDICARE SUPPLEMENT – A private medical expense insurance that supplements Medicare coverage. Also known as a Medigap policy.
MEMORANDUM OF AGREEMENT (MOA) – A written document, signed by two or more parties, containing policies and/or procedures for managing issues that impact more than one agency or program.
MEMORANDUM OF UNDERSTANDING (MOU) – Same as MOA
MENTAL ILLNESS – Collective term for all mental disorders. See also, MENTAL HEALTH, SERIOUS MENTAL ILLNESS, and SERIOUS AND PERSISTENT MENTAL ILLNESS.
MODEL FIDELITY – Adherence to evidence based practice (EBP) and fidelity to those specific program models that are shown to product consistently effective results.
NATURAL SUPPORTS - Places, things and, particularly, people who are part of our interdependent lives and whose relationships are reciprocal in nature and often vital to consumers' welfare.
NEEDS ASSESSMENT - A process by which an individual or system (e.g., an organization or community) examines existing resources to determine what new resources are needed or how to reallocate resources to achieve a desired goal.
NON-TARGET POPULATION – Individuals whose needs are met by community resources.
NORTH CAROLINA SUPPORT NEEDS ASSESSMENT PROFILE (NC-SNAP) – Assessment instrument used to determine the care or supports needed by a person with developmental disabilities.
OLMSTEAD v. LC – A U.S. Supreme Court decision that found that people with disabilities have a right to choose services in the least restrictive environment. North Carolina has an OLMSTEAD Plan in place to develop more community-based services for many people who currently reside in state institutions.
OPERATING COSTS means expenditures made by an area authority in the delivery of services for mental health, developmental disabilities, and substance abuse as provided in this Chapter and includes the employment of legal counsel on a temporary basis to represent the interests of the area authority.
OUTCOMES MEASURES – At the individual level, events used to determine the extent to which service consumers improve their levels of functioning, improve their quality of life, or attain personal life goals as a result of treatments, services and/or supports provided by the public and/or private systems. At the system level, these are events used to determine if the system is functioning properly.
OUTPATIENT SERVICES – A collection of services for persons with mental illness or addiction disorders. They may include any of the following but are not limited to assessment, medication management, psychotherapies, family therapy, care coordination

or case management, supportive employment programs, housing assistance, rehabilitation programs and activities, Assertive Community Treatment (ACT), Homeless Outreach, prevention programs, and others. Outpatient services can be provided in a variety of settings, including the person's home, and contain a few or any number of service elements.

PAID SUPPORTS - The people, places and things that are part of our lives because we purchase them in order to achieve specific outcomes.

PEER SUPPORT – Services offered by mental health consumers, persons with addictions or others to provide support to one another. Peer support services can include drop-in centers, bridge programs, warm lines, peer respite care or support groups. Peer support services are often a part of rehabilitation and recovery programs.

PERFORMANCE IMPROVEMENT – A quality improvement process of measuring and improving system performance, especially regarding key domains of interest.

PERFORMANCE MEASURES – Quantitative measures of the quality of care provided by a provider that consumers, payers, regulators and others can use to compare the care or provider to other care or providers.

PERIODIC SERVICES – Short-term re-occurring visits over time.

PERSON-CENTERED PLANNING - A process concerned with learning about the individual's whole life, not just the issues related to the person's disability. The process involves assembling a group of supporters, on an as-needed basis, who are selected by the individual with the disability and who have the closest personal relationship with them and are committed to supporting the person in pursuit of real life dreams. The planning process is interested in learning that the person is as an individual and what he/she desires in life. The process is interested in identifying and gaining access to supports from a variety of community resources, one of which is the community mental health, developmental disabilities and substance abuse services system that will assist the person in pursuit of the life he/she wants. Person-centered planning results in a written individual support plan.

PRE-AUTHORIZATION – The process of approving use of certain resources in advance rather than after the service has been provided. Approval for admission to hospitals is one example.

PREVENTION – Activities aimed at teaching and empowering individuals and systems to meet the challenges of life events and transitions by creating and reinforcing healthy behaviors and lifestyles and by reducing risks contributing mental illness, developmental disabilities and substance abuse. Universal prevention programs reach the general population; selective prevention programs target groups at risk for mental illness, developmental disabilities and substance abuse; indicated prevention programs are designed for people who are already experiencing mental illness or addiction disorders.

PRIOR AUTHORIZATION – A managed care process that approves the provision of services before they are delivered.

PRIORITY POPULATIONS – Groups of people within target populations who are considered most in need of the services available within the system.

PROVIDER – A person or an agency that provides mh/dd/sa services, treatment, supports.

PSYCHOSOCIAL REHABILITATION – A variety of social, learning, vocational and community living skill-building programs. Programs that focus on principles of recovery often achieve very successful outcomes.
PUBLIC MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES SYSTEM – The network of managing entities, service providers, government agencies, institutions, advocacy organizations, commissions and boards responsible for the provision of publicly funded services to consumers.
PUBLIC SERVICES means publicly funded mental health, developmental disabilities, and substance abuse services, whether provided by public or private providers.
QUALIFIED PROVIDER – A provider who meets the provider qualifications as defined by rules adopted by the Secretary of Health and Human Services.
QUALITY ASSURANCE (QA) - process to assure that services are minimally adequate, client rights are protected, and organizations are fiscally sound. QA involves periodic monitoring of compliance with standards. Examples include:
Establishment of minimum requirements for documentation and service provision.
Licensure and certification of individuals, facilities, and programs.
Investigation of allegations of fraud and abuse.
See also, QUALITY MANAGEMENT.
QUALITY IMPROVEMENT (QI) – process to assure that services, administrative processes, and staff are constantly improving and learning new and better ways to provide services and conduct business. The goals of QI are consistent with the mission and vision of the Division. As distinct from QA, the purpose of QI, also referred to as continuous quality improvement (CQI), is to continuously improve the process and outcome (quality) of treatments, services, and supports provided to consumers. QI consists of the regular and systematic assessment of vital indicators of organizational performance (i.e., data), the identification and evaluation of trends, and when problems are identified, systematic problem-solving to develop solutions to the identified problems. Special teams may be developed to further investigate and propose solutions to identified problems. Solutions to organizational problems are implemented by quality improvement teams and are systematically evaluated for effectiveness and on-going problem-solving until a satisfactory resolution is reached. QI is proactive, seeking opportunities to continually improve processes to achieve better outcomes. Examples include:
Forming teams to identify data to be collected, retrieve the data, analyze it and design improvements in the system.
Development and implementation of evidence-based practice guidelines.
Conducting targeted studies to determine how to improve service delivery.
QUALITY MANAGEMENT (QM)- framework for assessing and improving services and supports, operations, and financial performance. Processes include:

- Quality assurance, such as external review of appropriateness of documentation.
- Quality improvement, such as design and implementation of actions to address access problems.
- Utilization review, such as the review of case records to determine appropriateness of services and documentation.

- Utilization management, such as the pre-authorization of inpatient services.

QUALIFIED PROFESSIONAL means any individual with appropriate training or experience as specified by the General Statutes or by rule of the Commission in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors.

RECOVERY – A personal process of overcoming the negative impact of a disability despite its continued presence. Like the victim of a serious accident who undergoes extensive physical therapy to minimize the impact of damaging injuries, people with active addictions as well as serious, disabling mental illnesses and developmental disabilities can also make substantial recovery through symptom management, psychosocial rehabilitation, other services and supports, and encouragement to take increasing responsibility for self.

REFERRAL - Establishing a link between a person and another service or support by providing authorized documentation of the person's needs and recommendations for treatment, services, and supports. It includes follow–up in a timely manner consistent with best practice guidelines.

RESPITE CARE – A service designed to provide temporary care for a person with a disability who ordinarily lives with family or friends, or to assume temporary responsibility for care of the person in his/her own home. This service provides back-up support and in some cases relief to persons responsible for care of ill or people with disabilities who ordinarily live in their household.

SAFETY NET - The responsibility of the public mental health, developmental disability and substance abuse services system to serve, treat and support seriously ill people who, no matter how needy, would not otherwise receive services.

SCREENING – An abbreviated assessment or series of questions intended to determine whether the person needs referral to a provider for additional services. A screening may be done face-to-face or by telephone, by a clinician or paraprofessional who has been specially trained to conduct screenings. Screening is a core or basic service available to anyone who needs it whether or not they meet criteria for target or priority populations.

SEAMLESS - Treatment system without gaps or breaks in service, such that persons being served transition smoothly and with ease from one treatment component to another.

SECRETARY means the Secretary of the Department of Health and Human Services.

SELF-DETERMINATION – The right to and process of making decisions about one's own life.

SEVERELY EMOTIONALLY DISTURBED (SED) – A designation for people under 18 years of age who, because of their diagnosis, the length of their disability and their level of functioning, are at the greatest risk for needing services.

SEVERELY MENTALLY ILL (SMI) – Refers to adults with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services and/or supports. People with serious mental illness are a target or priority population for the public mental health system for adults.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) – Refers to people whose mental disorder is so severe and chronic that it prevents or erodes development of their functional capacities in primary aspects of daily life such as personal hygiene and self care, decision-making, interpersonal relationships, social transactions, learning and recreational activities. Same as SERIOUS, DISABLING MENTAL ILLNESS AND CHRONIC MENTAL ILLNESS.
SERVICE – A fixed and defined arrangement, such as social work services or nursing services, which are delivered within a scope of professional practice.
SERVICE MANAGEMENT - At the consumer level, this means a professional, with a great deal of knowledge of the services and programs supported by the public system, managing a set of services by advocating for access and linking the person to the services. At the system level, this means activities such as implementing and monitoring a set of standards for access to services, supports, treatment; making sure that people receive the appropriate level and intensity of services; management of state facilities' bed days, making sure that networks create consumer choice in service providers.
SPECIALTY SERVICES - Services provided to people with disabilities that affect relatively few people.
SSA - (Social Security Administration) The agency designated by the governor and the state government to coordinate state substance abuse services across government lines.
STANDARDS – Activities generally accepted to be the best method of practice. Also, the requirements of licensing, certifying, accrediting, or funding groups.
STANDARD OF CARE – A diagnostic and/or treatment process that a clinician should follow for a certain type of patient, illness or clinical circumstance.
STATE MENTAL HEALTH AUTHORITY – The single state agency designated by each state's governor to be responsible for the administration of publicly funded mental health programs in the state. In North Carolina that agency is the Department of Health and Human Services.
STATE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES PLAN – The annually updated statewide plan that forms the basis and framework for mh/dd/sa services provided across the state.
STATE OR LOCAL CONSUMER ADVOCACY COMMITTEE MEMBER - The individual carrying out the duties of the state Local Consumer Advocacy Program Office
STATE RESOURCES means State and federal funds and other receipts administered by the Division.
STIGMA – In this case, negative attitudes towards people with mental illness, developmental disabilities or addiction disorders.
SUBSTANCE ABUSE – The DSM IV defines substance abuse as occurring if the person 1) uses drugs in a dangerous, self defeating, self destructive way and 2) has difficulty controlling his use even though it is sporadic, and 3) has impaired social and/or occupational functioning all within a one year period.
THE SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION OF THE FEDERAL GOVERNMENT (SAMHSA) - SAMHSA is an agency of the U.S. Department of Health and Human Service. It is the federal umbrella agency of the Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and the Center for Mental Health Services.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) - A federal program to provide funds to states to enable them to provide substance abuse services.
SUBSTANCE DEPENDENCE - DSM IV defines substance dependence as requiring the presence of tolerance, withdrawal, and/or continuous, compulsive use over a 1year period.
SUPPORTS – Any of a large number of flexible activities or material resources intended to assist people to gain and maintain meaningful lives as citizens of their communities. See NATURAL SUPPORTS, PAID SUPPORTS
SUPPORT BROKER – A staff person who acts as an intermediary between the individual who needs supports and the agencies or programs that actually provide the supports.
SYNAR AMENDMENT – Section 1926 of the Public Health Service, is administered through the Substance Abuse Prevention and Treatment (SAPT) Block Grant and requires states to conduct specific activities to reduce youth access to tobacco products. The Secretary of the US Department of Health and Human Services is required by statute to withhold SAPT Block Grant funds (40% penalty) from states that fail to comply with the SYNAR Amendment.
SYSTEM PERFORMANCE - The extent that a system achieves its goals. The goals of the state mh/dd/sa system are found in the DMH/DD/SAS mission, vision and guiding principles.
SYSTEM PERFORMANCE MEASUREMENT - The process of assessing progress toward achieving state mh/dd/sa system goals and whether or not its principles have been applied and upheld.
TARGET POPULATIONS –Groups of people with disabilities with attributes considered most in need of the services available considering resources within the public system. See also, PRIORITY POPULATIONS.
TIMELY SERVICES - Access to services in a timeframe appropriate to their needs. Appointment with a physician within 72 hours of discharge from an acute psychiatric hospital unit is an example. See also, PROMPT SERVICES.
TRANSITION – The time in which an individual is moving from one life/development stage to another. Examples are the change from childhood to adolescence, adolescence to adulthood and adulthood to older adult.
TREATMENT - The planned provision of services that are sensitive and responsive to a patient's age, disability, if any, gender and culture, and that are conducted under clinical supervision to assist the patient through the process of recovery.
TRIAGE - One name for a process by which people are assessed to determine the type of services and level of care they will require.
UNIFORM PORTAL ACCESS - The standardized process and procedures used to ensure consumer access to, and exit from, public services in accordance with the State Plan.
UTILIZATION MANAGEMENT (UM) - a process to regulate the provision of services in relation to the capacity of the system and needs of consumers. This process should guard against under-utilization as well as over-utilization of services to assure that the frequency and type of services fit the needs of consumers. UM is typically an externally imposed process based on clinically defined criteria.

UTILIZATION REVIEW (UR) - an analysis of services, through systematic case review, with the goal of reviewing the extent to which necessary care was provided and unnecessary care was avoided. UR is typically an internally imposed process that employs clinically established criteria.
VOLUME OF SERVICES – Method of representing the amount of services provided by a service provider.
WITHDRAWAL - A psychological and / or physical syndrome caused by the abruptly stopping or reducing substance use that has been heavy and prolonged. The symptoms include clinically significant distress or impairment in social, occupational or other important areas of functioning and are not due to a general medical condition or accounted for by another mental disorder.

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Appendix D. Detailed Tasks and Status of Tasks from Prior State Plans

This appendix lists the detailed tasks from each of the five State Plans and the status of each, with explanation if necessary. Status is indicated as either completed, partially completed, to be done, or deleted. Note that tasks indicated as "completed" indicates that it was completed for that fiscal year and does not indicate it would not be undertaken at another time. Tasks that are "deleted" are either not appropriate as a task of implementation of the reformed system or tasks that are beyond the control of the Division. Such tasks may be appropriate as goals for the operating system once it is fully implemented.

These tasks have been reviewed by the External Advisory Team that was established by the Division Director for the purpose of advising the Division about the State Plan and other major projects such as the Long-Range Plan.

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
1	Initiate plan to coordinate policies and planning with other divisions to address administrative and business functions, funding sources, as well as programmatic & clinical guidelines, outcomes and initiatives		1-Completed	
2	Provide initial report to Legislative Oversight Committee on state plan, and quarterly thereafter on each required activity listed below.		1-Completed	
3	•Submit the State MH/DD/SAS Plan to the Legislative Oversight Committee	1.5, 3(1)(a)	1-Completed	
4	•Review of rules and statutes inside and outside DHHS	3(a)(2)	1-Completed	
5	•Review oversight & monitoring functions implemented by DHHS	3(a)(3)	1-Completed	
6	•Report on development of service standards, outcomes, financing formula for core and targeted services, to prepare for their admin, financing & delivery by area authorities/county programs	3(a)(4)	1-Completed	
7	•Develop format & required content for business plans submitted by boards of county commissioners & for contractual agreements between DHHS & area authorities/county programs	3(a)(5)	1-Completed	
8	•Assessment of DHHS readiness for reform implementation	3(a)(6)	1-Completed	
9	Expand service capacity for substance abusers to assist in diversion from state psychiatric hospitals		2-Partially completed	Renovations to expand detox capacity at ADATCs completed at R.J. Blackley ADATC. Still in process at J. F. Keith and W. B. Jones

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
10	•Division of Facility Services to give priority consideration to construction on projects related to the development of service capacity		4-Delete	DFS must follow the requirements of the State Medical Facilities Plan and timelines.
11	•DHHS personnel to expedite additional staffing needs of Alcohol & Drug Abuse Treatment Centers (ADATC)		3-To be done	Capital projects have experienced delays. Units slated to open in SFY 2007. When funding appropriated by the GA, DHHS HR will establish and level positions.
12	New Director of MH/DD/SAS announced		1-Completed (twice!)	
13	DD to convene workgroup to build plan for integrating private Intermediate Care Facilities/MR into unified community-based system		1- Completed	Although DD section no longer exists, new unified way of determine ICF/MR Level of Care through Murdoch Center does integrate community ICFs/MR into standard practice.
14	Prepare, with the County Commissioner's Association, a technical assistance/communication plan for decision regarding Letters of Intent.	3(a)(8)	1 - Completed	This was in anticipation of the catchment area consolidation plan that was submitted by the Secretary on 1/1/2005.
15	Distribute revised service record manual to field staff for review		3-To be done	Currently being finalized.
16	Submit a research waiver for consumer directed services for people with developmental disabilities		2 - Partially completed	CMS has changed the process and this goal is no longer obtained through a research waiver; it is now a Home and Community Based waiver. DMH/DD/SAS has prepared a waiver application that is currently under review by DMA.
17	Revise service definitions for July implementation of Integrated Payment & Reporting System (IPRS) statewide rollout & establish plan for:	3(a)(4)	1 - Completed	
18	•Submit changes to Medicaid Plan & coordinate with Health Choice & state funding as needed	1.5	1-Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
19	•Promulgate rules & publication of activities as required by the rule-making authority (G.S. 150B) & new Medicaid legislation		1 - Completed	Completed for what was envisioned in State Plan 2001; however, rule-making is an on-going process.
20	•Analyze financial impact		1-Completed	
21	•Begin training of staff & field staff		1-Completed	
22	•Set rates for new services		1-Completed	
23	•Electronic Data Systems (EDS) & IPRS programming		1-Completed	
24	Begin establishment of licensure rules through MH Commission on MH/DD/SAS for prevention program		2-Partially completed	Prevention services still being designed. Also plan to pursue elimination of licensure for outpatient SA services.
25	•Develop criteria for qualified prevention professional		1-Completed	
26	Based on Olmstead assessments, analyze services needed to facilitate discharge of patients from state hospitals and reduce admissions to such hospitals.		2- Partially completed	Consumers have been discharged and consumers needing the services they were receiving are no longer being admitted to hospitals. However, overall admissions have increased due to increase in population, decrease of community hospital capacity and SA admissions.
27	Complete annual public review of plan		1-Completed	
28	Complete annual public review of plan		1-Completed	
29	Establish outpatient crisis teams from state facilities to develop re-integration plans		4-Delete	Decision was made that these teams did not need to be housed in state facilities; community providers are capable of delivering the services envisioned.
30	Report to Appropriations Committee finding of Section 21.28A of Senate Bill 1005, Traumatic Brain Injury Waiver		1 - Completed	
31	Implement plan to divert substance abuse admissions from state psychiatric hospitals		3-To be done	Plan has not been implemented since capital projects to create detox capacity in ADATCs have taken longer than anticipated.
32	•Complete renovation of 3 ADATCs for 90 additional beds		2-Partially completed	Renovations completed at R.J. Blackley ADATC. Still in process at J. F. Keith and W. B. Jones

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
33	•Recruit & hire for 90 additional beds		2-Partially completed	Staff hired for Blackley. Staff will not be hired at Keith and Jones until renovations completed.
34	Develop multilevel integrated quality management committee structure including consumers, families and other stakeholders		2-Partially completed	This is an on-going process.
35	Develop and/or strengthen collaborative agreements with community college systems, DPI, colleges and universities, Area Health Education Centers & associated training vendors to establish training for state plan, best practices including cultural competence		1- Completed	
36	•Develop & present funding needs for competency programs		4-Delete	Training required by service definitions has taken a different track from what was originally envisioned in 2001.
37	•Complete content competencies for each curriculum & establish inter-rater reliability		4-Delete	
38	Complete 1 through 5 year financing plan to support mission core services, target populations, LME functions, state functions, bed-day allocations, mental retardation center downsizing, leveraging funds from state facilities & Mental Health Trust Fund	3(a)(4)	3-To be done	Vendor has been selected to develop financing plan. Final product scheduled to be delivered November, 2006.
39	•Review current allocations of state funding to area authorities/county programs & recommend changes in methods & formulae to ensure equitable distribution of state funds & evaluate means of increasing/realigning funding to stabilize & support MH/DD/SAS	3(a)(4)	3-To be done	
40	•Develop accurate picture of current resource allocation in the MH/DD/SAS System including current methods of funding & disparities	1.5, 3(a)(4)	3-To be done	
41	•Develop a realignment plan of state facility resource		1-Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
42	•Develop a dedicated source of ongoing of state & federal funding for the system		4-Delete	DMH/DD/SAS does not have the ability to develop state or federal funding sources. That is dependent upon the appropriating bodies.
43	•Examine ways to obtain additional funding through traditional/non-traditional means		2-Partially completed	Vendor has been selected to develop financing plan. Final product scheduled to be delivered November, 2006.
44	•Complete analysis and make recommendations for direct/indirect cost of qualified public/private providers		1-Completed	
45	Develop criteria & operational procedures for the Consumer Advocacy Program	Part 2	1-Completed	
46	Develop the DHHS Appeals Panel for clients and family members, as well as qualified providers	3(a)(7) ??	3 - To be done	Rules being developed and considered by the Commission for MH/DD/SAS.
47	Evaluate consolidation of the Quality of Care Consumer Advocacy Program w/other consumer advocacy /ombudsman programs in DHHS and report to the LOC. Include Consumer Advocacy Programs, Office of Consumer Affairs		1- Completed	Evaluation was completed but never submitted to LOC, since they had not requested it to be.
48	Establish training & promotion strategies for state plan		1-Completed	
49	Present integration of the Olmstead, Long-term Care & State MH/DD/SAS plans		4- Delete	Other Plans have legislative language requiring them to remain separate plans.
50	Review financing options for interpretation/translation services to people being served and make specific recommendations		1-Completed	
51	Initiate expansion of community support services for adults with mental illness in order to facilitate closure of state hospital beds.	1.1	1-Completed	
52	Provide financial and/or technical assistance to LME's to enhance service development/provision to the adult mental health target population.	3(a)(5)	1-Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
53	Complete analysis and make recommendations for direct/indirect cost of qualified public/private providers	1.5	1-Completed	
54	Open admissions at 3 ADATCs to involuntary substance abuse admissions		1-Completed	
55	Adopt a standardized assessment & treatment protocol and provide regional training to area authority/county program and ADATC staff in order to carry out diversion of substance abuse clients to state hospitals		2-Partially completed	Completed for Blackley since renovations complete. To be done at Keith and Jones when detox capacity comes on line.
56	Present recommendations regarding expansion of direct enrollment of qualified providers & possibly agencies		1-Completed	
57	Complete annual State Plan modification	1.5, 3(1)(a)	1-Completed	
58	Update all Memoranda of Agreement (MOA) for July implementation		1-Completed	
59	Complete data gathering and analysis related to geographic (catchment) area consolidation plan	3(a)(8)	1-Completed	
60	Complete review of state plan for FY 02-03 implementation	1.5, 3(1)(a)	1-Completed	
61	Submit quarterly report for LOC on status of state plan implementation		1-Completed	
62	Increase target populations of children w/severe impairment & their families to be served through SOC		1-Completed	
63	•FY 2002-6000 youth/families (doubling 3,000 baseline of youth served in System Of Care (SOC) currently eligible for At Risk SOC in 100 counties)		4-Delete	SOC has been expanded statewide. Arbitrary numerical goals were not supported by data.

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
64	Establish annual 5 year benchmarks to: 1) strengthen school counseling programs, primary care linkage & qualified provider networks through SOC approach for 253,407 with mild/moderate impairment; 2) incorporate prevention through SOC targeting 1,851,191 y		2 - Partially completed	Linkage to primary care and SOC goals is ongoing process.
65	Assess with Community Collaborative the current service array & gaps in services to establish baseline		3-To be done	Included in the Long Term Plan RFP to be completed July 2006.
66	Develop local services to reduce the number of children in state hospitals, DSS custody & Youth Development Centers	1.1	1-Completed	
67	Increase capacity using 3% of Child Mental Health funds pool (approx. 1.5 million) for comprehensive treatment services special provision to children with highly complex needs		1-Completed	
68	SOC for children At Risk or already out-of home operational in 30 counties		1- Completed	
69	Refine collaborative plan with other child-serving agencies/communities to expand resources through integration of services		1- Completed	
70	Increase/add resources for CMH at the community level at 25%		4-Delete	Requires additional appropriations. Goal is laudable; firm numerical target is unrealistic
71	Recommend integrated SOC structure that includes JCPC through legislation/executive order to reduce duplication		1- Completed	
72	Establish flexible funds & voucher resources across all disabilities		4-Delete	Requires legislative action; no current support
73	Modify CAP/MR-DD waiver to expand community-based services		1-Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
74	Initiate rule revisions on an ongoing basis as systems & policies are implemented	3(2)(a)	1-Completed	
75	Eliminate 72 state psychiatric hospital beds & transfer patients to community		1-Completed	
76	•Dix Hospital 39 beds-close Wright Building		1-Completed	
77	•Broughton Hospital 18 beds-close nursing facility		1-Completed	
78	•Umstead Hospital close 15 gero-psychiatry beds		1-Completed	
79	Systematically and on ongoing basis, redirect funds from state hospitals to community services for substance abuse, mental health, child mental health to expand community services		1-Completed	
80	Prepare Eastern Adult Treatment Program, Whitaker & Wright Schools for Medicaid certification		4-Delete	EATP closed. Physical plants at Wright and Whitaker cannot be cost-effectively made to meet CMS requirements (State does not even own Wright School property.)
81	Develop cross agency policy recommendations for statewide outcomes based SOC best practices consistent with state plan		1- Completed	
82	Implement comprehensive outcome measurement plan with elements across agencies and develop framework for outcome report cards	3(a)(4)	3-C	Quality Management Team working with stakeholders to develop appropriate system- and provider-level reports.
83	Implement SA standardized risk assessment protocol and pilot use in 10 communities		4-Delete	NC TOPPS informing development of risk assessment. When complete, will be rolled out statewide, not piloted.
84	Develop 2 pilot projects from ICF-MR homes to community support using CAP-MR/DD funds		4-Delete	New CAP-MR/DD waiver facilitates movement from community ICFs/MR to CAP waiver. No need to pilot, is working statewide.
85	Mental retardation centers & private sector develop 5-bed homes in community for those person previously unsuccessful in community placements		4-Delete	Decision has been made that state developmental centers will not be developing community-based services at this time.

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
86	HB 1395 Transfer-ICF-MR beds to transfer at least 40 people from mental retardation centers to community ICF-MR beds		3 - To be done	HB 1395 transfers were "on hold" for a number of years. DHHS has now decided to revisit the issue and begin pursing this option in the future.
87	Develop & operate three 12-bed specialized MR/MI units one for children, two for adults in each of the 3 MRCs to serve moderate to severe MR & MI for crisis intervention, diagnosis & treatment		4-Delete	Further research has not supported this level of increased institutional capacity. SOS is working with developmental centers to identify need for MR/MI capacity.
88	Convert Black Mountain Center ICF-MR beds to Skilled Nursing Facility to serve aging persons with DD & medical care needs		1-Completed	
89	Develop MH/DD/SA protocols based on evidence-based practices and/or national standards of service delivery		1-Completed	
90	•Develop service definitions consistent with evidence-based services/expert consensus	1.5(9)	1-Completed	
91	•Update clinical guidelines for client assessment, schizophrenia, mood disorders, substance related disorder and psychiatric issues in persons with MR		2-Partially completed	Design and implementation of new service array caused this deliverable to be put on the back burner. Best Practice Team now revisiting.
92	•Making use of Robert Wood Johnson/SAMHSA and other national tool kits as appropriate, review & evaluate standards on person-centered planning, cultural competence, Assertive Community Treatment, psychiatric rehabilitation and case management for adults		1-Completed	
93	Develop specs for DHHS management information system including decision support & build upon Medicaid MIS & IPRS for DHHS coordination; manage coordination at department level		1- Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
94	Develop Memoranda Of Agreement between state & local agencies including qualified provider enrollment agreement and qualified provider/LME agreements		1-Completed	
95	Establish local monitoring protocols for use by LME & credential local auditors; coordinate with Division of Facility Services licensure review including relationship with national accreditation & deemed status	3(a)(9)	1-Completed	
96	Establish Office of Consumer Affairs that is consistent with Division reorganization		1-Completed	
97	Develop readiness plan for conducting reviews & certifying area authorities/county programs as LME's.		1-Completed	
98	Reduce child out-of-state placements by 25%		1- Completed	
99	Promote increased flexibility of child-serving funds-develop mechanisms in 100 counties to de-categorize 1-5% of child-serving agency funds		4-Delete	DMH/DD/SAS has allowed LMEs to decategorize up to 10% of CTSP funds. Funding for other agencies is beyond the scope and authority of DMH/DD/SAS
100	Establish regional learning center-engage university & community college systems with team of specialists of trainers in each region for TA in best practices and trouble-shooting. One center per year for 4 years		4-Delete	DMH/DD/SAS does not have sufficient infrastructure to operate regional training facilities
101	Identify all existing outcome tools and data collection efforts across agencies that can contribute to one integrated data set to measure indicators regarding specified outcome targets		4 - Delete	DMH/DD/SAS is developing outcome tools and measurement processes. Measurement of outcomes by other agencies is beyond the scope of the Division
102	Present quarterly report to the LOC on the status of State Plan implementation		1-Completed	
103	Receive and act on letters of intent from counties regarding LMEs	3(a)(8)	1-Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
104	Develop criteria for performing Utilization Management including centralized functions & LME functions		1-Completed	
105	•Develop budget & fee structure for UM functions		1-Completed	
106	•Develop criteria for measuring the performance of the UM entity on an ongoing basis		1- Completed	
107	•Begin process for the selection of a vendor		1-Completed	
108	•Determine process & content of UM information to state & LME	3(a)(4)	3-To be done	Working with the Division of Medical Assistance and ValueOptions to develop reports and formats.
109	Present quarterly report to the LOC on the status of state plan implementation		1-Completed	
110	Develop and maintain a mh/dd/sa competency, education and training system that is coordinated among system members & is based on best practices including cultural competence, professional competencies, and performance standards		4-Delete	Training required by service definitions has taken a different track from what was originally envisioned in 2001.
111	Develop & maintain a workforce that is reasonably compensated		4-Delete	Beyond the scope of DHHS. We can establish services rates but we cannot dictate to private providers how much they pay their staff. Market forces control that. We can also require certain training as a compliance measure, but cannot dictate types of voluntary staff development activities.
112	•Develop & periodically update career enhancement procedures for the MH/DD/SA system		4-Delete	
113	•Perform regular salary reviews to ensure a workforce that is reasonably compensated at the local community level (public & private)		4-Delete	
114	Each area authority/county program submits their proposed business plan to the DHHS Secretary	3(a)(8)	1-Completed	
115	Establish licensure categories for agencies providing non-facility based services & begin rule making		4-Delete	Working to eliminate licensure requirements for non-facility based services.

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
116	Create separate Home and Community Based (HCB) waiver for persons leaving institutions		4-Delete	Guidance from CMS and experiences in other states indicate this is not a viable plan
117	Reduce alcohol, tobacco & other drugs (ATOD) usage by children between the ages of 12-17		4-Delete	We have reduced this, however, this is an on-going goal which cannot be achieved in a two-year period of time.
118	•Work with Center for Substance Abuse Prevention to identify a menu of approved prevention services		1-Completed	
119	•Develop prevention service system, definitions, staff competencies & outcome criteria		1-Completed	
120	•Initiate negotiations with Medicaid & other payers to establish rates & approve reimbursement for prevention services in NC		3-To be done	DMH/DD/SAS successfully applied for and received a federal Prevention Strategic Infrastructure Grant (P-SIG) which is informing this activity.
121	Complete annual public review of plan	1.5, 3(1)(a)	1-Completed	
122	Establish a 24-bed substance abuse crisis triage unit and complementary intensive outpatient program for Wake County		4-Delete	Wake County chose to concentrate on creating inpatient capacity.
123	•Identify & renovate an appropriate facility		4-Delete	
124	•Recruit & hire staff		4-Delete	
125	•Evaluate progress in development and implementation of seamless electronic communication systems across agencies and qualified providers (MMIS/IPRS, etc.)		2-Partially completed	Clinical applications being designed for new hospital will form the baseline for this activity.
126	Complete annual plan modification	1.5, 3(1)(a)	1-Completed	
127	Present quarterly report to the LOC on the status of the State Plan implementation		1-Completed	
128	Re-engineer home & community-based waiver services to reflect Human Service Research Institute recommendations		1- Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
129	Continue expansion of local community child and adolescent service array increasing resources at the community level by 35%		4-Delete	Dependent upon increased funding by GA
130	Continue rollout for county integrated child SOC to cover 50 counties		1- Completed	
131	Increase target population of children with severe impairment to be served by SOC to build capacity for 18,000 youth/families		1-Completed	
132	The Secretary shall complete certification of 1/3 of area authorities/county programs as LME's	3(a)(8)	1-Completed	
133	Develop statewide contract for referral system component for Uniform Portal		1- Completed	
134	Reduce additional 154 adult state hospital beds & substitute with community based services including pilot projects for specialized residential services, community nursing facilities, and other supports		1-Completed	
135	Rollout a reimbursable substance abuse prevention benefit for 1,500 children and their families		4-Delete	Dependent upon funding
136	Establish 2nd of 4 regional learning centers to provide ongoing TA & troubleshooting for system		4-Delete	DMH/DD/SAS does not have sufficient infrastructure to operate regional training facilities
137	Refine comprehensive outcome plan including common elements from other agencies for cross-agency outcome report cards.		3-Completed	Work on reporting outcomes for DMH/DD/SAS outcomes ongoing.
138	Complete research & development of uniform set of funding band criteria to transition to a new resource allocation system		1-Completed	
139	Present quarterly report to the LOC of the status of the state plan implementation		1-Completed	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
140	DHHS Secretary shall complete certification of two-thirds of the area authorities/county programs as LME's	3(a)(8)	1-Completed	
141	Complete annual public review of plan	1.5, 3(1)(a)	1-Completed	
142	Present quarterly report to the LOC on status of state plan implementation		1-Completed	
143	Develop 5 additional community based substance abuse crisis triage units with Intensive Outpatient treatment programs		4- Delete	Initial state plan envisioned that DMH/DD/SAS would develop these programs. We are currently working with LMEs and providers to develop them locally.
144	Complete annual plan modification	1.5, 3(1)(a)	1-Completed	
145	Present quarterly report to the LOC on the status of state plan implementation		1-Completed	
146	Continue cross-agency approaches to comply with Olmstead and comprehensive treatment program special provision by reducing out-of-state child placements 75%		1- Completed	
147	Reduce number of children inappropriately in state hospitals, DSS custody and youth development centers by redirecting funds from state hospitals to established local & semi-regional alternatives to increase by 25%		3-To be done	Demand for children's' inpatient services has continued to be steady so units have not been able to be downsized. We anticipate that new services that became effective 3/20/06 will begin to impact this demand positively.
148	Continue rollout schedule for counties to use SOC to 70 counties		1-Completed	
149	Increase target population of children with severe impairment to 36,000 youth/families		1-Completed	
150	Reduce ATOD use by children 12-17 by standardized data collection for measuring outcomes and to begin risk profiling of this group		4- Deleted	

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
151	Continue to reduce state hospital placements for children by establishing 4 regional assertive community treatment teams in conjunction with 4 semi-regional psychiatric hospitals		4-Delete	ACTT is not an evidence-based practice for children. New services implemented 3/20/06 include Intensive In-Home and Multi-Systemic Therapy which are evidence-based practices appropriate for children.
152	Continue to increase/add resources for child community service array by 50% and SOC for children & youth operational in 80 counties		1-Completed	
153	Establish number 3 out of 4 regional learning centers to provide ongoing TA and trouble shooting for statewide system		4-Delete	DMH/DD/SAS does not have sufficient infrastructure to operate regional training facilities
154	DHHS Secretary shall complete certification of all area authorities/county programs as LME's	3(a)(8)	1-Completed	
155	Eliminate additional 212 state adult hospital beds		1-Completed	
156	•Integrate & refine community planning based on state plan		1-Completed	
157	•Expand specialized nursing bed capacity by 20 beds at 4 sites		2-Partially completed	One pilot is currently operating to determine the cost-effectiveness of this proposal.
158	•Expand specialized residential service with 12 beds at 6 sites		4-Delete	12 bed group homes are not best practice. They continue to perpetuate the notion of segregating and congregating individuals with disabilities. Providers developed alternative living arrangements for consumers being discharged from state hospitals and DHHS continues to work to expand housing options in inclusive settings.
159	•Place 60 people in community programs based on Olmstead assessments		3-To be done	Downsizing of state Developmental Centers has not occurred as planned, despite efforts of DMH/DD/SAS.
160	Present quarterly report to the LOC on the status of state plan implementation		1-Completed	
161	Present statewide system report card covering the plan implementation, client outcomes and system reform		2-Partially completed	Quality Management Team is developing appropriate system- and provider-level reports. The first semi-annual report on system performance was provided to the LOC October 2006.

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
162	Present quarterly report to the LOC on the status of State Plan Implementation		1-Completed	
163	Present the Secretary's area authority/county program consolidation plan to the LOC	3(a)(8)	1-Completed	
164	Complete annual public review of plan	1.5, 3(1)(a)	1-Completed	
165	Present quarterly report to the LOC on the status of the state plan implementation		1-Completed	
166	Develop 10 additional community step down residential alternatives with Intensive Outpatient Program for substance abusers		4-Delete	Initial state plan envisioned that DMH/DD/SAS would develop these programs. We are currently working with LMEs and providers to develop them locally.
167	Complete annual plan modification	1.5, 3(1)(a)	1-Completed	
168	Present quarterly report to the LOC on the status of the state plan implementation		1-Completed	
169	SOC for children shall be operational in all 100 counties		1-Completed	
170	Continue to reduce children in state hospitals, DSS custody and youth development center by re-directing funds from state hospitals to local and semi-alternative regional alternatives		3-To be done	Demand for children's' inpatient services has continued to be steady so units have not been able to be downsized. We anticipate that new services that became effective 3/20/06 will begin to impact this demand positively.
171	State plan should be substantially implemented with continuing build-up of service array of SOC, evidence-based practices, ongoing indices accomplishment and areas of improvement		1 - Completed	
172	Strategies and schedules for implementing a phased in plan to eliminate disparities in the allocation of state funding across county programs and area authorities	1.5	3-To be done	Funding study awarded to vendor; scheduled to be completed November, 2006
173	The total number of area authorities and county programs shall be reduced to no more than 20		4-Delete	Secretary's plan submitted to LOC on 1/1/2005 no longer adheres to goal of 20 LMEs

#	State Plan 2001 Tasks	Section of Session Law 2001-437	Status: 1-Completed, 2-Partially completed, 3-To be done; 4-Delete	Explanation
174	Persons served in mental retardation centers reduced 50%		4 - Delete	Downsizing of state Developmental Centers has not occurred as planned, despite efforts of DMH/DD/SAS. Current evaluation of projected capacity needed exceeds 50% of current beds. This goal was not realistic.

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
1	The Division will oversee the mh/dd/sas reform effort.	Part 3	1-Completed	
2	The Division will ensure ongoing implementation of the State Plan.	Part 3	1-Completed	
3	The Division will ensure that all planning is done in collaboration with all stakeholders.		1-Completed	
4	The Division will oversee a state-level transition strategy to assist the reform.	Part 3	1-Completed	
5	The Division will undergo a reorganization to support the mh/dd/sas State Plan.	1.5	1-Completed	
6	Division staff will organize and support the Director's Advisory Committee on implementation of mh/dd/sas reform.		1-Completed	
7	The Division will create an Office of Advocacy & Customer Services.	Part 2 ??	1-Completed	
8	The Division will sponsor an annual consumer conference and other conferences as approved by the Director.		1-Completed	
9	The Division will provide guidance and oversight of meaningful participation/ involvement by consumers/families at the local policy level.		1-Completed	
10	The Division will assure appointment of consumers/family members to state-level boards, commissions, advisory bodies, planning groups and other appropriate bodies.		1-Completed	
11	The Division will assure that all statutes, rules and policies that are inconsistent with mh/dd/sas reform are identified, amended and/or deleted. In cases where federal and/or state statutes cannot be modified or waived, the Division will assure that mh/dd/sas policy is in compliance.	3(a)(2)	2-Partially completed	This is a work in-progress with the Commission for MH/DD/SAS. All rules that need to be deleted have been identified, however, other more pressing issues such as the Child Residential Rules or actions of the General Assembly requiring rule-making, such as pseudo ephedrine legislation, have prevented staff and the Commission from completing this task.

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
12	The Division/ Department will conduct an analysis of the state statutes to ensure congruity with foundations and models of best practice.		1-Completed	
13	The Division will create a regulatory and policy framework to facilitate mh/dd/sas reform.		1-Completed	
14	The Division will develop all statewide contracts necessary to implement mh/dd/sas reform and ensure that each is processed expeditiously.		1-Completed	
15	The Division will develop a technical assistance/ communication strategy to assist counties with choosing a method of governance.		1-Completed	
16	The Division will ensure that local business plans are submitted in accordance with reform statute and are consistent with State Plan requirements.	3(a)(5)	1-Completed	
17	The Division will provide standardized protocols and documents for use by the LMEs to ensure consistency across the state.		1-Completed	
18	The Division will provide guidance and oversight to ensure that targets and parameters for consolidation in the reform statute are met.	Part 3	2-Partially completed	Division has provided guidance, technical assistance, and funding. However, we do not have statutory authority to force mergers.
19	The Division will develop and oversee training and technical assistance to assist in development of local management entities.	1.5(9)	2-Partially completed	This is a work in progress. Division continues to offer technical assistance and guidance.
20	The Division will oversee the transition from the current local system to a strong LME public management system.	Part 3	2-Partially completed	On-going
21	The Division will oversee the implementation of state rules, policies and standards in state facilities.		1-Completed	

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
22	The Division will provide adequate monitoring and oversight of state services and facilities.	3(a)(3)	1-Completed	
23	The Division will facilitate the collaboration between state-operated services and LMEs.	1.6	1-Completed	
24	The Division will adopt statewide uniform procedures for all facilities to expedite movement of individuals into community.		1-Completed	
25	The Division will develop and implement category-specific downsizing plans, including strategies for bed/census reductions and community capacity development.		1-Completed	
26	Psychiatric hospitals will be downsized to meet State Plan requirements.		1-Completed	
27	The Division will adopt a plan to divert individuals in the substance abuse target population from state psychiatric hospitals.		2 - Partially completed	Renovations at completed to expand detox capacity at R. J. Blackley. Renovations still in progress at J. F. Keith and W. B. Jones
28	The Division will adopt and implement a plan for decreasing by 50% the long-term census of the state's mental retardation centers (MRCs).		4-Delete	Division continues to work with consumers, providers, parents to comply with Olmstead ruling implications at the state developmental centers. An arbitrary 50% reduction is no longer seen as viable.
29	The Division will adopt and implement a plan for eliminating state-operated facilities for SED children and youth and expanding System of Care (SOC) in communities.		4-Delete	System of Care has expanded statewide. Demand for children's impatient services has continued to be steady. We expect to continue to need inpatient capacity at all three hospitals for the foreseeable future.
30	The Division will approve and monitor performance goals submitted via local business plans (LBPs).	3(a)(5)	1-Completed	
31	The Division will oversee compliance of LMEs with LBP planning and/or approved local business plans.	3(a)(5)	1-Completed	

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
32	The Division will manage annual agreements/ contracts with LMEs to govern funding allocations.	3(a)(5)	1-Completed	
33	The Division will oversee development and management of a new utilization management (UM) system throughout the state.		3 - To be done	Standardized UR processes for Medicaid funded services will be implemented with the implementation of the Value Options process. The Division is still working on standardized authorization criteria for state funded services. Will be finalized early in SFY 2007.
34	The Division will develop disability-specific service/care authorization criteria.		3-To be done	
35	The Division will oversee system development based on best practice foundations and practice platforms.	1.5(9)	1 - Completed	Note that this will continue to be an on-going process. The Division has established the Practice Improvement Collaborative (PIC) comprised of academics, clinicians, consumers and providers to oversee this process in the future.
36	The Division will provide leadership in transformation to a system with best practices as its foundation.	1.5(9)	1-Completed	
37	The Division will develop a comprehensive training strategy to support the principles of the State Plan.		2 - Partially completed	Initial training has been conducted on all service definitions and in-depth training is on-going for several. The complete training plan for each definition will be published in June, 2006.
38	The Division will oversee development, implementation and evaluation of core functions by the LMEs.	1.1	1- Completed	The Division has defined and offered guidance on these. Ongoing monitoring and a continuous quality improvement process will be on-going.
39	The Division will provide guidance to local communities with respect to building community capacity and resource enhancement.		1 - Completed	The Division has provided guidance. Development of community capacity at the local level will be an on-going process.
40	The Division will develop uniform service definitions to enhance the array of services/supports/ treatment to target populations based on models of best practices in identified essential life areas.	1.5(7)	1-Completed	
41	The Division will develop uniform practice standards based on models of best practices in essential life areas.	1.5(9)	2-Partially completed	The Division has addressed best practices in services and in some life areas, such as housing and work. The PIC will continue this process in other life areas.

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
42	The Division will develop standards and practices to enhance system-wide focus on prevention.		2-Partially completed	Division successfully applied for and received a federal Prevention Strategic Infrastructure Grant (P-SIG) which is informing this activity.
43	The Division will design the statewide system of uniform portal (standardized access to services).	1.5(8)	2-Partially completed	A standardized screening tool and a standardized assessment tool will be published in the first quarter of SFY 2007.
44	The Division will provide for a single statewide access point to work in tandem with local systems.		4-Delete	Upon further investigation, the technology to support this goal is not available. Now that telephone numbers are portable, an automated system that could recognize an area code and redirect the call to the proper LME does not work.
45	The Division will institute access system performance standards.		1- Completed	
46	The Division will develop reporting procedures regarding access.		1-Completed	
47	The Division will develop and execute a comprehensive quality management (QM) system focusing on continuous quality improvement.		2-Partially completed	On-going
48	The quality management system will be outcome-based.		2-Partially completed	On-going
49	The Division will develop performance indicators for all levels of the system to be included in the quality management process.		2-Partially completed	Process of refining performance measures in on-going.
50	The Division will develop measurement criteria for models of best practice to be included in QM system.		2-Partially completed	Now that we have finally received CMS approval of the new service definitions and have been able to implement evidence-based best practices, we will begin process of developing mechanisms and tools for monitoring providers for fidelity to the evidence-based models.
51	The Division will develop a monitoring and oversight process as part of the QM system.	Part 2	1 -Completed	
52	The Division will incorporate consumer rights, protections, appeals and grievances into the overall QM system.	3(a)(2)	2-Partially completed	This has been completed for consumer rights and critical incidents. Incorporation of complaints and appeals is in progress.

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
53	The Division will establish competency requirements for all segments of the mh/dd/sa workforce.		4 - Delete	Training required by services definitions has taken a different track from what was envisioned in 2002.
54	The Division will manage a comprehensive training and education strategy to support the new quality management system.		4 - Delete	DMH/DD/SAS does not have sufficient infrastructure to "manage a comprehensive training and education strategy." We have developed requirements around provider training that we believe accomplishes this goal.
55	The Division will conduct internal evaluations of state performance for public review.		2- Partially completed.	In the process of developing performance criteria to measure internal performance. The first semi-annual report on system performance was provided to the LOC October 2006.
56	The Division will create a methodology for conducting continuous quality improvement (CQI) for state operations.		1-Completed	
57	The Division will participate in national studies and evaluations.		1-Completed	An ongoing activity.
58	The Division will explore opportunities for additional external review.		1-Completed	The new service definitions and the LME contract require services providers and LMEs to be subject to review by national accrediting bodies. SAMHSA reviews the Division.
59	The Division will create a performance based contracting system.		1-Completed	
60	The Division will evaluate the efficacy of statewide utilization management (UM).		1- Completed	Division strongly supports statewide UM and is in the process of implementing that standardization.
61	The Division will create the framework for building a financial strategy to support reform.	1.5(12), 3(a)(4)	3-To be done	Funding study awarded to vendor; scheduled to be completed November, 2006
62	The Division will maximize the use of all funding sources.		1-Completed	
63	The Division will develop the capacity to convert funding from institutional programs for use in community settings.	1.5(12)	1-Completed	
64	The Division will manage and oversee transition to a system of fair and equitable resource allocation methodology.		3-To be done	Funding study awarded to vendor; scheduled to be completed November, 2006

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
65	The Division will institute independent cost modeling of new system functions.		1-Completed	
66	The Division will establish state-level procedures to enable fiscal reform.		3-To be done	
67	The Division will redesign its fiscal policies and practices as necessary to support best practices.	1.5	1-Completed	
68	The Division will oversee the implementation of the Integrated Payment and Reporting System (IPRS).		1-Completed	
69	The Division will implement and oversee the new Decision Support System.		1-Completed	
70	The Division will develop and implement a plan for seamless electronic communication systems across agencies and qualified providers.		3-To be done	Clinical applications being designed for the new hospital will form the baseline for this activity.
71	The Division will provide leadership in use of technology to improve the mh/dd/sa system and support to individual users.		1- Completed	
72	The Division will provide technical guidance and/or leadership in selection/ development of a consumer centered, outcome focused electronic health record system.		3-To be done	The Division is participating in the HIS system development
73	The Division will ensure local compliance with state and federal technology and data standards, with special emphasis on compliance with HIPAA standards.		1-Completed	
74	The Division will oversee the continued technological developments at the local level.		1-Completed	
75	The Division will participate in and/or create new partnerships with state agencies to facilitate reform.	1.5(9)	1-Completed	
76	The Division will enhance existing joint efforts in the areas of training and education.		1-Completed	

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
77	The Division will participate in departmental level initiative to address workforce issues in human services.		1- Completed	
78	The Division will increase participation in the Long Term Care Cabinet.		1-Completed	
79	The Division will engage in cross- departmental strategies to address prevention issues consistent with the State Plan.		3-To be done	Division successfully applied for and received a federal Prevention Strategic Infrastructure Grant (P-SIG) which is informing this activity.
80	The Division will work with the Division of Facility Services (DFS) to modify licensure statutes, rules and practices to promote best practices.		2-Partially completed	This is a work in-progress with the Commission for MH/DD/SAS (not DFS). All rules that need to be deleted have been identified and revised rules are in progress, however, other more pressing issues such as the Child Residential Rules or actions of the General Assembly requiring rule-making, such as pseudo ephedrine legislation, have prevented staff and the Commission from completing this task.
81	The Division will initiate collaborative efforts to improve the linkage between mh/dd/sas and primary health care.		1-Completed	
82	The Division will work with DHHS staff and Office of State Personnel to address implications of reform on the state/local public workforce.		1-Completed	
83	The Division will oversee collaborative efforts to help de-construct the existing silos (an agency practice of operating without input or involvement of other agencies or parts of agencies).		1-Completed	
84	In collaboration with appropriate state agencies, state and local media, LMEs and advocacy organizations, the Division will increase awareness of the mh/dd/sa reform effort and the new system that is envisioned.		2-Partially completed	

#	State Plan 2002 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
85	In collaboration with LMEs, advocacy and consumer organizations, the Division will create a local development strategy to engender support for the new system and promote the vision of people with disabilities as full citizens of their communities.		1- Completed	

#	State Plan 2003 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
1.1	Establish departmental project team		1-Completed	
1.10	Conduct a comprehensive evaluation of reform		3-To be done	Working on this prior to the implementation of the new services would have been premature.
1.11	Develop new or modify existing statutes that reflect mh/dd/sa reform		3-To be done	Legislation pending in the 2006 Session.
1.12	Analyze, establish, or modify rules to reflect service system design		2-Partially completed	This is a work in-progress with the Commission for MH/DD/SAS. All rules that need to be deleted have been identified, however, other more pressing issues such as the Child Residential Rules or actions of the General Assembly requiring rule-making, such as pseudo ephedrine legislation, have prevented staff and the Commission from completing this task.
1.13	Obtain approvals from commissions, grant authorities, federal agencies		1- Completed	
1.2	Develop a comprehensive communication plan		1- Completed	
1.3	Develop a training and education plan		2- Partially Completed	Final communication regarding trainings approved to meet requirements of new service definitions will be issued in June, 2006.
1.4	Develop area program/county program consolidation plan		1-Completed	
1.5	Submit quarterly reports to legislative oversight committee and other legislative reports as required		1-Completed	
1.6	Publish draft state plan 2004		1-Completed	
1.7	First level commitment		1-Completed	
1.7	Piedmont Project		1-Completed	
1.7	Deaf and Hard of Hearing		1-Completed	
1.7	Coordinate activities of the Health Information Systems (HIS)		1-Completed	
1.7	Coordinate activities of the MMIS plus rebid		1-Completed	
1.7	Coordinate activities for HIPAA compliance		1-Completed	

#	State Plan 2003 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
1.7	Wake County In-patient		4- Delete	DHHS continues to assist Wake County where possible on this issue, but this is a Wake County project.
1.7	Authorizations by LME's		3-To be done	Standardized authorization guidelines for state funded services to be issued in the first quarter of SFY 2007.
1.7	Participation in Guardianship Study		4- Delete	There has not been interest among other agencies to pursue this matter at this time.
1.8	Coordination with the division stakeholder group and the public policy work group		1-Completed	
1.9	Coordinate process to hire a clinical director		1-Completed	
2.1	Policy decisions on county funds/ MOE		1-Completed	
2.1	Policy decisions on Medicaid match		1-Completed	
2.1	Establish the long-term financial plan including identification of revenues and transition implementation steps. This also includes the policy decisions regarding local maintenance of effort and equity of funding		3-To be done	Vendor has been selected. Final report due November, 2006.
2.1	Equity funding		3-To be done	
2.11	Modify and distribute manuals to reflect changes		2- Partially Completed	All new manuals have been published with the exception of the Service Records Manual which will be published in July, 2006.
2.12	Analyze decisions for fiscal impact on other service systems such as DSS, DJJDP and criminal justice and publish information		4-Delete	This is beyond the scope of DHHS
2.13	Coordinate decisions with office of state budget		1-Completed	
2.14	Coordinate decisions with local government commission and association of county commissioners		1-Completed	
2.15	Coordinate with controller's office changes for payments		1-Completed	
2.16	Coordinate bed day allocation plan for hospitals		1-Completed	
2.17	Coordinate bed day allocation plan for ADATCs.		1-Completed	

#	State Plan 2003 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
2.18	Develop MR centers downsizing plan		1- Completed	Plan has been completed. However, despite the Division's best efforts, downsizing has not occurred as planned.
2.19	Coordinate with hospital downsizing plan		1- Completed	Hospital downsizing plan has been completed. However, demand for hospital services remains high and downsizing has not occurred as planned.
2.2	Establish funding for LME services based upon cost model		1-Completed	
2.3	Establish and modify standards for fund balance requirements		1-Completed	
2.4	Establish methodology for service rates to providers		1-Completed	
2.5	Publish service rates		1-Completed	
2.6	Load and coordinate rate changes and structures with IPRS and MMIS.		1-Completed	
2.7	Establish, modify or repeal fiscal requirements such as cost findings.		2- Partially Completed	Revised policy guidance has been issued regarding fiscal policies. Revision of rules and APSM-75 manual are in process
2.9	Modify state contracts as needed		1-Completed	
3.1	Child mental health plan		1-Completed	
3.10	Establish documentation requirements for triage/screening/referrals		1-Completed	
3.11	Establish provider qualifications for all services including case management.		1-Completed	
3.12	Develop utilization and authorization protocols (medical necessity determination)		2- Partially Completed	Medicaid completed; authorization guidelines for state funded services to be issues in the first quarter of SFY 2007
3.13	Establish provider network requirement including contracts and enrollment		1-Completed	Note that the term "provider network" has a negative connotation with CMS and is no longer included in our vocabulary!
3.13	Policy decision for direct enrollment		1-Completed	
3.13	Policy decision for direct billing		1-Completed	
3.13	Establish authorization documentation to providers		1-Completed	

#	State Plan 2003 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
3.13	Establish authorization and connectivity/documentation to payer		2-Partially completed	Working to standardize the forms to be used in this process
3.18	Modify state contracts as needed		1-Completed	
3.19	Modify, submit and secure approval of HCB waiver		1-Completed	
3.19	Development of new waiver(s) and/or technical amendments to an existing waiver		1-Completed	
3.19	Coordinate TBI waiver		4-Delete	The decision was made by the TBI Council that a waiver was not the best solution for that population.
3.2	Operationalize child mental health plan		1- Completed	
3.2	Establish process for operationalization of the CMH Plan		1-Completed	
3.2	Implement the CMH Plan		1-Completed	
3.20	Modify and publish manuals (services, medical record, waiver, Medicaid, and clinical guidelines)		2- Partially Completed	All new manuals have been published with the exception of the Service Records Manual which will be published in July, 2006.
3.21	Establish and implement training and communications for programmatic products		2- Partially Completed	Final communication regarding trainings approved to meet requirements of new service definitions will be issued in June, 2006.
3.22	Coordinate with health choice		1-Completed	
3.23	Coordinate with state personnel classification changes		1- Completed	
3.24	Establish comprehensive prevention plan		2-Partially completed	Division successfully applied for and received a federal Prevention Strategic Infrastructure Grant (P-SIG) which is informing this activity.
3.25	Comprehensive service implementation plan		1- Completed	
3.26	Implementation of construction plan for ADATC acute detox admissions		1-Completed	
3.27	Develop consolidation plan for hospitals (Dix/Umstead)		2-Partially completed	Hospital Steering Committee working on this activity
3.28	Establish and coordinate uniform and consistent operational policies and practices for all state facilities		2-Partially completed	State Operated Services staff continues to work on this project.

#	State Plan 2003 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
3.29	Develop comprehensive quality management and systems evaluation plan		2-Partially completed	Overall Quality Management plan completed in SFY 2005.
3.3	Complete DD best practice		2-Partially completed	Will be finalized in first quarter of SFY 2007
3.30	Review quality assurance plans in accordance with CMS quality protocol for waivers		1- Completed	
3.4	Design uniform portal (designs and access standards for target/ non-target including triage and screening).		1-Completed	
3.4	Establish standards and functionality requirements for telephonic connectivity among the State, LMEs and providers		4-Delete	Upon further investigation, the technology to support this goal is not available. Now that telephone numbers are portable, an automated system that could recognize an area code and redirect the call to the proper LME does not work.
3.5	Establish triage/ screening protocols		1-Completed	
3.6	Establish staff qualification for triage and screening		1- Completed	
3.7	Establish referral protocols		1- Completed	
3.8	Establish person centered planning standards and documentation elements		1-Completed	
3.9	Write service definitions		1-Completed	
4.1	Establish state CFAC operations plan		1-Completed	
4.10	Establish state and local monitoring requirements including protocols and audits procedures.		1-Completed	
4.13	Establish training and communication plan to reflect administrative changes		1- Completed	
4.14	Modify and distribute manuals to reflect changes		3-To be done	All new manuals have been published with the exception of the Service Records Manual which will be published in July, 2006.
4.15	Integration of information technology between facilities		2-partially complete	The new clinical applications being developed for the new hospital will form the foundation for continuing this effort.
4.16	Develop an accreditation policy for LMEs and providers		1-Completed	

#	State Plan 2003 Tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially completed; 3-To be done; 4-Delete	Explanation
4.2	Establish local CFAC operations plan		1-Completed	
4.3	Establish LME director evaluations		1-Completed	
4.4	Establish performance contract between LME and state		1-Completed	
4.5	Establish provider agreements and or contracts for service providers		1-Completed	
4.5	Coordinate network capacity development		2-partially complete	Provider capacity issues will continue to be addressed through the Provider Action Agenda Team, which expands July 1, 2006 to include provider members. With the implementation of the new service definitions and direct enrollment for providers, provider capacity can now be addressed in a more systematic manner.
4.6	Establish memorandum of agreements between state partners (division and departments)		1- Completed	
4.7	Establish technology requirements including but not limited to client data		2-partially complete	Continue to work on developing more web-based solutions for various reporting requirements.
4.8	Establish telephone connectivity between LME and providers		4-Delete	Beyond the scope of DHHS
4.9	Establish cohesive service provider appeal system		1-Completed	
4.9	Establish cohesive LME appeal system		1-Completed	
4.9	Establish cohesive consumer appeal process		2- Partially Completed	Working with the Commission on MH/DD/SAS to develop rules as required by 2005 legislation
	Distribute completed LME cost model and negotiation parameters		1-Completed	
	"Seal" model based upon feedback		1-Completed	
	Finalize LME payment rates for each LME		1-Completed	
	Establish cost allocation, payment and settlement methodology for LME payments		1-Completed	
	Policy decision on the benefits package for target and non-target		1-Completed	

#	State plan 2004 tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially complete; 3-To be done; 4-Delete	Explanation
1.15	Continue to advance the public policy relationship between the state and its local partners through the on-going work of public partners policy group		1-Completed	
1.16	Develop a cultural competency and awareness plan for the Division, LMEs, providers and partners		2-Partially complete	The plan has been completed in draft and disseminated for comments. It will be finalized and implemented in the first quarter of SFY 2007.
1.17	Publish state plan 2005		1-Completed	
1.18	Advance the awareness of customer service throughout the division to reflect the DHHS secretary's initiative & coordinate efforts with communications and training team to establish training and keep it on-going		1- Completed	
2.2O	Finalize rates for service		1-Completed	
3.30	Continue research, dissemination and implementation of new best practices		1- Completed	Though this will be an on-going process, the Division has established the Practice Improvement Collaborative (PIC) comprised of academics, researchers, consumers, and clinicians to systematically and routinely consider new and emerging best practices.
3.31	Develop independence plus waiver		2-Partially complete	The waiver has been completed and is awaiting DMA approval. There is some concern on the part of DMA that this waiver cannot be implemented prior to the implementation of NC LEADS.
3.32	Develop and implement plans and activities that respond to the 2003-2004 recommendations of the commission on mh/dd/sas task force on housing particularly in the areas of division and LME capacity building and public education		1- Completed	The Division has implemented the components of the plan that are within its jurisdiction and that are possible within existing resources. Additional funding is required to further implement the plan.
3.33	Provide technical assistance around natural and community supports for non-target individuals		2-Partially complete	Will be finalized as a component of the standardized authorization for state funded services.
3.34	Oversee implementation of the piedmont project		1- Completed	Ongoing
3.35	Implement new CAP-MR/DD waiver		1-Completed	
3.36	Continue development of the area program/ county program consolidation plan		1-Completed	

#	State plan 2004 tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially complete; 3-To be done; 4-Delete	Explanation
3.37	Support and serve the target populations and continue to evaluate the target populations to determine necessary adjustments		1-Completed	
3.38	Complete comprehensive prevention plan		2-Partially complete	Division successfully applied for and received a federal Prevention Strategic Infrastructure Grant (P-SIG) which is informing this activity.
3.39	Coordinate hospital downsizing		2-Partially complete	Demand for hospital services has remained high so downsizing has not proceeded at the pace anticipated. It continues to be a work in progress.
3.40	Distribute approved service definitions with accompanying provider qualifications and utilization management guidelines		1-Completed	
3.41	Develop plan for systems to transition to new support and service expectations		1-Completed	
3.42	Implement the division's workforce development plan		3-To be done	Communications & Training Team leader position has been vacant for more than a year. Numerous postings have not resulted in an acceptable candidate. We believe we are close to hiring someone and this will be one of their top priorities.
3.43	Coordinate state developmental centers downsizing		2-Partially complete	Downsizing of state developmental centers has not occurred as planned, despite efforts of DMH/DD/SAS
3.44	Continue implementation of the child mental health plan		1- Completed	
4.20	Work with the division of medical assistance to revise the state Medicaid plan to advance reform efforts		1-Completed	
4.21	Develop standardized LME-provider contract, utilization management criteria, and billing procedures		2- Partially complete	Contract and billing guidelines have been completed. Standardized authorization guidelines for state funded services will be issued early in SFY 2007.
4.22	Continue technical assistance in building community capacity for service and service divestiture		1-Completed	

#	State plan 2004 tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially complete; 3-To be done; 4-Delete	Explanation
4.23	Continue technical assistance and consultation regarding the functions of the LMEs		1-Completed	
4.24	Refine the requirements and timelines for accreditation for LMEs		1-Completed	
4.25	Refine the requirements and timelines for accreditation for providers		1-Completed	
4.26	Develop and implement a plan for expanding community education regarding reform		1- Completed	
4.27	Develop quality reports		2-Partially complete	Many reports have been developed. Focus in SFY 2007 will be on creating easy to read, visually interesting reports.
4.28	Provide training for LME staff in customer service and rights protection		4-Delete	DMH/DD/SAS does not have sufficient staff to perform this function. We have made customer services materials to LME staff development coordinators and encouraged them to use those materials to train their own staff.

#	State plan 2005 tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially complete; 3-To be done; 4-Delete	Explanation
1.1	Continue to implement information sessions with the leadership of key state agencies and associations to discuss issues related to transformation of the mh/dd/sa system		1-Completed	
1.2	Develop outline for the local business plan		1-Completed	
1.3	Develop succession plan for continued leadership in the state operated facilities		2-Partially complete	Several unexpected vacancies have made this task more critical and more difficult
1.4	Develop succession plan for continued leadership at the division's central office		2- Partially complete	Division is participating in DHHS succession planning activities
1.5	Develop and implement memoranda of agreement describing relationships between the division and other state agencies		1- Completed	
1.6	Develop a long range plan for addressing the mental health, developmental disabilities, and substance abuse services needs of the state		3-To be done	Vendor has been selected and work is underway. Final report due July, 2006
2.1	Develop finance strategy		3-To be done	Vendor has been selected and work is underway. Final report due November, 2006
2.2	Develop and re-evaluate rates		1-Completed	
2.3	Develop strategic plan for resource development		3-To be done	Vendor has been selected and work is underway. Final report due November, 2006
3.1	Submit self directed services and supports waiver for persons with developmental disabilities to the federal Centers for Medicare and Medicaid services (CMS)		2-Partially complete	DMH/DD/SAS has completed draft waiver. Currently pending approval at DMA. Concerns at DMA that implementation may have to be delayed due to systems constraints until new MMIS system goes on-line
3.10	Implement comprehensive prevention plan		2-Partially complete	Division successfully applied for and received a federal Prevention Strategic Infrastructure Grant (P-SIG) which is informing this activity.
3.11	Implementation and evolution of child mental health plan		1-Completed	
3.12	Continue to offer technical assistance on community capacity functions of the LME		1- Completed	

#	State plan 2005 tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially complete; 3-To be done; 4-Delete	Explanation
3.13	Continue initiative pertaining to traumatic brain injury		1-Completed	
3.14	Evaluate the availability and access to medications for persons served by the mh/dd/sa system		2-Partially complete	Working to establish better pharmaceutical access
3.15	Develop best practice for self-directed services		1-Completed	
3.2	Successfully implement all new services including those in the new CAP-MR/DD waiver		1- Completed	
3.3	Utilization review implementation		2-Partially complete	Authorization guidelines for state funded services to be finalized during first quarter of SFY 2007
3.4	Develop three region concept		1-completed	
3.5	Enhance collection of data on consumer outcomes and experiences		2-Partially complete	Completed for MH and SA populations; to be completed for DD population in SFY 2007
3.6	Develop provider reports		2-Partially complete	Will be completed in SFY 2007
3.7	Address homelessness		2-Partially complete	This is an on-going effort
3.8	Study and re-evaluate service definitions		1-Completed	
3.9	Initiate transition to new service expectations		1-Completed	
4.1	Implement the recommendations of the cultural competency advisory group		2-Partially complete	To be finalized and implemented in the first quarter of SFY 2007
4.10	Publish state plan 2006		2-partially complete	Awaiting guidance from pending legislation
4.11	Develop new or modify existing rules and statutes that reflect mh/dd/sas reform		2-partially complete	This is a work in-progress with the Commission for MH/DD/SAS. All rules that need to be deleted have been identified and revised rules are in progress, however, other more pressing issues such as the Child Residential Rules or actions of the General Assembly requiring rule-making, such as pseudo ephedrine legislation, have prevented staff and the Commission from completing this task.

#	State plan 2005 tasks	Section of Session Law 2001-437	Status: 1-Completed; 2-Partially complete; 3-To be done; 4-Delete	Explanation
4.2	Oversee key components in the development of the new hospital at Butner		2-Partially complete	Hospital Steering Committee continues to monitor this activity
4.3	Continue quality improvement initiatives for the mh/dd/sa services system		2- Partially complete	Ongoing activity
4.4	Continue to develop policies of state operated facilities wherever possible to consolidate for uniformity the operations of the state service delivery system		2-Partially complete	State Operated Services continues to work on this project
4.5	Implement the strengthening and enhancement of the division's accountability efforts		2-Partially complete	New positions have finally been approved and interviews are in process.
4.6	Develop performance measures around the functional efforts of CFACS		2-Partially complete	Advocacy and Customer Services are working with CFACs on this project
4.7	Develop and implement strategies for training and workforce development		2-Partially complete	Communications & Training Team leader position has been vacant for more than a year. Numerous postings have not resulted in an acceptable candidate. We believe we are close to hiring someone and this will be one of their top priorities.
4.8	Continue housing initiatives for persons served by the mh/dd/sas system		2-partially complete	Ongoing activity
4.9	Advance the opportunities for people with disabilities and their families to influence the full range of the system		2-partially complete	Continue to work to increase consumer and family participation